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## The Sixth Annual Charles V. Chapin Oration

### THE CONTROL OF TYPHUS FEVER\*

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IN SELECTING me to present the Charles V. Chapin Oration, the Rhode Island Medical Society has done me great honor and admitted me to cherished privileges. This distinction has come to me, I realize, not for original contributions to preventive medicine and public health, but through the association I have had the good fortune to enjoy with some of the leaders in public health administration and investigators of infectious diseases. I feel that I have accepted the honor in the names of these men and of the military and civilian groups which were effective teams of the type fostered by Doctor Chapin. It has been their purpose, as it was his, to get at the facts of situations, determine the best relevant scientific information, attack unsolved problems, and apply accurate information for the public welfare. These have been concerted activities of operative epidemiology. The privileges to which you have admitted me have been more personal. The occasion has renewed associations with friends in this distinguished Society. Furthermore, in preparing for this oration I have read a number of the papers by Doctor Chapin and accounts of his life and service. This has brought me into contact with the spirit of a great man.

When I told your officers that I should like to talk about typhus control, one of them expressed

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uncertainty as to the appropriateness of the topic as it might seem too remote or exotic for this audience. As you are not troubled with typhus in Rhode Island, that may be so. Louse-borne epidemic typhus has not been a serious problem in New England since early in the last century, and it is unlikely that it will be a problem in a community such as yours which has the intelligence, knowledge and means to prevent the spread of the disease. In these days of airplane travel, however, a case of louse-borne typhus might occur even in Providence in some passenger whisked by air from a typhus area abroad during the incubation period of the disease. Such things have occurred in recent years in several places in the United States. Imported laborers from a country where typhus is endemic have been known to introduce the disease into states in which it had not occurred previously. There may be peculiar latent infections in rodents or human beings that are the residues of earlier importations of one form of typhus or another<sup>2, 43</sup>. Although rare, these are of interest. Occasionally, flea-borne or murine typhus has occurred in New England. In Massachusetts and Rhode Island no distinction is made between Brill's disease and murine typhus. It is not possible to tell, therefore, how many of the few reported cases of "endemic typhus" were Brill's disease, now regarded by many as epidemic typhus from the work of Zinsser and Plotz<sup>43, 26</sup>. Tick-borne spotted fever, of the Rocky Mountain spotted fever group, occurs near enough to Rhode Island to warrant maintenance of an alert for cases. Other rickettsial infections are not remote. Q fever<sup>13, 36</sup> has been seen as an importation, but not as a spreading disease, in these parts, and the newly recognized mite-borne rickettsial pox<sup>21, 22</sup> of last year's outbreak in one of the five burroughs of New York City, is of direct interest

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to physicians and public health officers of Rhode Island.

In many ways Rhode Island, although free from typhus, has common interests with the rest of the world in the investigation and control of all the rickettsial diseases<sup>17</sup>. Information gained from the study of the intracellular rickettsiae sheds light on similar organisms and their activities in other diseases. The development of insecticides against lice, fleas, ticks and mites because they transmit rickettsial infections becomes of practical value in many other situations in places where these diseases rarely, if ever, occur. Rodent control devised to reduce murine typhus in the South has possibilities for saving losses of lives and produce in New England when applied for other reasons. Chemotherapy of typhus fevers contains promises for advance in the treatment of other diseases<sup>18, 34, 40</sup>. There is a oneness and continuity in all biological work of this type, as there is a oneness of the world united by necessity in defense against enemies which menace health.

Epidemic typhus which through the centuries has been a hindrance to military operations and a devastating calamity for populations afflicted by war and shortages of food and the means for keeping free of vermin, united many interests for the defense of our country, the winning of World War II and the safeguarding of occupied regions. Not one but several forms of typhus fevers became of first rank importance to this nation. In the preservation of the health of soldiers, who were both our kinfolk and our representatives, typhus control was important to every home from which these men came. All may take pride and satisfaction in the achievements along these lines which make a brilliant chapter in military preventive medicine and contribute directly to national and international public health.

In general, the account of typhus control has an appeal as a good story. With the exception of Q fever, the rickettsial diseases are transmitted by insects, various arthropods, such as lice, fleas, ticks, and mites. Doctor Chapin,<sup>10</sup> who in his essay in 1885 on "The Present State of the Germ Theory of Disease" was one of the first in this country to realize and accept the importance of Pasteur's discoveries, was interested both in the spread of disease by contact and its transmission by insects. I found little or nothing about typhus in his papers that I examined, but did find several evidences that the exotic aroused his interest. In his paper in 1927<sup>11</sup> on "The Principles of Epidemiology," speaking of disease transmitted by insects, he wrote: "The development of our knowledge of these diseases furnishes the most fascinating chapter in medical history."

A part of the modern chapter on the control of typhus fevers will be presented here. The material

for it has been drawn from so many sources that detailed acknowledgment of all of them will not be attempted. A few selected references are appended.

### *Rickettsial Diseases of Man*

The rickettsial diseases of man are caused by small microorganisms which occupy a position somewhere between the bacteria and viruses. In man and animals these organisms usually occur within the cells of endothelial lining of blood vessels. They have not been cultivated outside of the presence of living cells. Nearly all are transmitted by insects (various arthropods), and some have reservoirs in the lower animals such as rats, rabbits and dogs. Their cycles of growth and transmission are complicated and are not fully known in all instances. As the cycles of growth and transmission of the more important rickettsial diseases of man involve a stage in insects they are particularly vulnerable to attack directed against the insect vectors. Such vectors and reservoirs can be destroyed. Hence control measures are largely based upon eradication, destruction, or control of the insect transmitters of these diseases. It is well to recall here that modern work along these lines is not yet forty years old. It stems from two fundamental discoveries made in 1909. In that year Howard Taylor Ricketts,<sup>28, 29</sup> of the University of Chicago, discovered the organism causing typhus fever. In his honor the genus was named *Rickettsia*. In the same year, Charles Nicolle<sup>25</sup> of the Pasteur Institute of Algiers, proved that typhus fever is transmitted from man to man by the body louse. Ricketts' discovery was the basis of all modern *specific* diagnosis, serum therapy and the prevention and amelioration of typhus by immunization, as well as a vast amount of research. To say this does not belittle the value of knowledge gained from the use of the Weil-Felix agglutination reactions with various types of *Proteus* bacilli. Those reactions have been indispensable for diagnosis and epidemiology. But the explanation of their basis has not yet been provided, and therefore Weil-Felix tests remain outside the field of rickettsial specificity. Nicolle's discovery redirected the attack against the louse vector in epidemic typhus. As Zinsser<sup>42</sup> has said: "The strategic initiative passed into the hands of man, with the discovery in 1909, by Charles Nicolle. The victim was in a position to organize a rationally planned and strategically sound defense against his historic enemy." This defense is chiefly an attack upon the insect vector.

The rickettsial diseases of man, with some selected information about the organisms causing them, the animal reservoirs, insect vectors, modes of transmission and chief control measures may be grouped and summarized in the following table (Table I).

TABLE I  
RICKETTSIAL DISEASES OF MAN

Disease	Causative Organism	Animal Reservoir	Insect Vector	Transmission	Control
I. LOUSE-BORNE: 1. Epidemic, exanthematic typhus	Rickettsia prowazekii	Man	Body louse, Pediculus humanus	By infected louse feces, through the skin, occasionally by inhalation and through conjunctiva.	Louse eradication and prevention, delousing, with insecticides (DDT, etc.), and heat. Vaccination, isolation, quarantine.
2. Trench fever	Rickettsia wolhynica	Man	Body louse	By infected louse feces, through skin.	Louse control
II. FLEA-BORNE: 3. Endemic, murine typhus	Rickettsia prowazekii (Var. typhi, or mooseri)	Rats	Rat fleas, chiefly Xenopsylla cheopis	By infected flea feces, through the skin.	Rodent control, and flea control, use of insecticide (DDT) in rat burrows, etc., vaccination.
III. TICK-BORNE: 4. Rocky Mountain spotted fever, in U. S. A. Western type Eastern type	Dermacentor variabilis rickettsi Dermacentor variabilis rickettsi	Rodents rabbits, dogs rabbits, dogs rabbits, dogs	Ticks, chiefly Dermacentor variabilis and Rhipicephalus sanguineus	By tick bite By tick bite By tick bite	Avoidance of infected areas, control of rabbits and dogs, removal of ticks, tick control by insecticides (developing), vaccination.
5. South American spotted fever	Rickettsia sp.?	Dogs, rodents, opossum (?)	Amblyoma cajannense	By tick bite	
6. South African tick typhus	Rickettsia sp.	Rodents and dogs?	Rhipicephalus evertsi	By tick bite	
7. Siberian tick typhus	Rickettsia sp.	Rodents	Dermacentor nuttali	By tick bite	
8. Indian tick typhus	Rickettsia sp.	Unknown	Tick sp.?	By tick bite	
9. North Queensland tick typhus	Rickettsia sp.	Unknown	Tick sp.?	By tick bite	
10. Fievre boutonneuse	Rickettsia conori	Dogs		By tick bite	As for spotted fever.
IV. POSSIBLY TICK-BORNE, BUT ALSO CONTAGIOUS: 11. Q fever	Rickettsia burneti	Bandicoot rodents sheep?, man	Possibly various ticks including Dermacentor andersoni and Amblyoma americanum	By tick bite possibly, and by inhalation.	Tick control, and respiratory disease control measures.
V. MITE-BORNE: 12. Scrub typhus, tsutsugamushi disease	Rickettsia tsutsugamushi (=orientalis)	Field voles and field rats	Larval mites, chiefly Trombicula deliensis	By bite of larval mite.	Ground clearance, avoidance of infected areas, use of miticides in clothing; vaccination to be developed.
13. Rickettsial pox	Rickettsia akari	House mice	Larval mite, Alloderma manissus sanguineus	By bite of larval mite.	Rodent control against mice.

### *Epidemic Louse-Borne Typhus*

When the United States entered the war in 1941, efforts already underway were intensified to devise better methods and to obtain better materials for the prevention and control of typhus fever. In this work numerous federal, military and civilian agencies and many individuals became united in the far-reaching type of collaboration that was characteristic of the allied war effort. The cooperating organizations included the Medical Departments and other divisions of the Army and Navy, the United States Public Health Service, the Department of Agriculture, the National Research Council, the Committee on Medical Research, the Rockefeller Foundation and the research and production divisions of chemical and biological manufacturing firms. Close liaison was maintained with Canadian and British laboratories and organizations concerned with typhus fever and other rickettsial diseases.

The attack on typhus was centralized and strengthened on December 24, 1942 by the establishment of the United States of America Typhus Commission<sup>3</sup> by President Roosevelt's Executive Order No. 9285. The need for a special commission on typhus became apparent from studies of the situation made in the Preventive Medicine Service of the Office of The Surgeon General of the Army in July 1942, when plans for the North African campaign were being discussed. The conception grew with increasing understanding of the extent of the problems and finally by act of the President, the United States of America Typhus Commission was created as a joint enterprise of the Army, Navy and United States Public Health Service under the supervision and direction of the Secretary of War "for the purpose of protecting the members of the armed forces from typhus fever and preventing its introduction into the United States." The Director of the Commission was "authorized and directed to formulate and effectuate a program for the study of typhus fever and the control thereof, both within and without the United States, when it is or may become, a threat to the military population." The establishment of this Commission and the powers conferred upon it constitute a remarkable phase of federal administrative attack upon a single disease, or, as it developed, upon the group of closely related diseases, epidemic typhus, murine typhus, and scrub typhus.

Executive Order No. 9285 placed a medical commission on a high staff level and provided for direct access of the Director of the Commission to the Secretary of War, and, with his sanction, to heads of general staff and service divisions, and to Theater Commanders. The experience of the Commission contains lessons of importance to both mili-

tary and civilian medical establishments. The question of the necessity for a special commission with such powers is debatable, and cannot be discussed without full consideration of the structure of the military services and the limitations placed upon functions of the regular medical departments. The problems of administration of a semi-autonomous commission in relation to the three great medical services, the successes and failures of the Commission, the operational and scientific activities of the Commission will be dealt with in a separate historical publication. It is sufficient to note here that the Commission was active in the United States and all theaters of operation overseas from January 1943 until the end of June 1946, when it was dissolved. It served as a main center of investigation and control of typhus fevers in the world-wide attack on those diseases required by the global military operations of American forces.

Practical results of importance and lasting benefit came from the collaboration of all the agencies mentioned above. In terms of products the two most notable achievements were the improvement of typhus vaccine and the development of lousicidal preparations, chiefly a powder, containing DDT (dichlorodiphenyltrichloroethane), discovered by Zeidler<sup>41</sup> in 1874. In terms of practice the method of using the vaccine for immunization and the methods of applying the louse powder to persons fully clothed were long steps ahead. In fact the utilization of DDT louse powder to control typhus was a revolutionary advance.

In 1941 it was foreseen that American troops might be sent to regions where typhus was prevalent. Although forecasts were made in 1942, the extent of the risk from exposure to infection was not known until afterward. The year 1942 was an epidemic typhus year among civilians in the Mediterranean region, from Morocco to Iran<sup>4, 20</sup>. In 1943-44 at a critical time in the Italian campaign there was a sharp and potentially dangerous outbreak of typhus in devastated Naples. Upwards of 20,000 cases of typhus were uncovered in the Rhineland, Inner Reich and Austria in the spring of 1945, while American troops were advancing. In the winter of 1945-46 the most severe epidemic of typhus in recent years occurred in Japan and Korea during the first six months of the occupation of those countries. The approximate numbers of reported cases among the civilians in these countries during the years 1942 to 1946 are summarized in Table II. From what is known about the deficiencies of the reporting systems in these countries, particularly during the war, it is reasonable to estimate that there were actually four to five times as many cases as the numbers reported.



TABLE II

Approximate Numbers of Reported Cases of Epidemic Typhus Fever Among Civilians in Various Countries During World War II.

Countries	(4 mths.)				
	1942	1943	1944	1945	1946
French North Africa (Morocco, Algiers)	77,335	27,340	6,226		
Egypt	23,941	40,084	18,533		
Iran	1,102	12,885	6,436		
Italy (chiefly Naples)	0	481	1,409		
Germany, Austria (occupied)	?	?	?	20,000	
Japan	100	1,414	3,964	2,460	27,150
Korea	3,150	8,850	5,400	13,100	4,100

There were only 64 reported cases of epidemic louse-borne typhus and no deaths from the disease among all American military personnel in all these typhus-infected areas during the years 1942 to 1946. The number of cases is probably less than 64, as it is believed that some cases in refugees and German prisoners treated in American military hospitals are included in the reports. Taking the number as 64, Sadusk<sup>30</sup> has calculated that the rate of epidemic typhus in the total American Army was 0.003 per 1000 per annum, with rates of 0.01 in the European Theater and 0.13 in the Mediterranean Theater of Operations. Among these cases there were instances of infection acquired not directly from lice but by the inhalation of infected louse feces or by entry of such material into the conjunctival sac.

The low incidence of typhus in American soldiers is attributed primarily to their freedom from lice and to the protective action of louse powders. The mildness of the disease, without fatality, is attributed to immunization by the vaccine, which ameliorates the disease although it does not prevent infection<sup>30</sup>.

Starting early in 1942 all United States military personnel stationed in or travelling through where typhus was known to exist were vaccinated against typhus<sup>30</sup>. As the destination of troops was not predictable, the vaccine was administered almost throughout the Army. The vaccine used was of the "Cox type," consisting of a suspension of typhus rickettsia of the Breinl strain cultivated in embryonated hen's eggs, extracted with ether according to Craigie's method, and fortified by the addition of specific rickettsial soluble substance<sup>14, 15, 27, 35</sup>. To get the advantage of revival and heightening of immunity by "booster doses" individuals were reinjected with the vaccine at intervals of 6 months or oftener, depending upon the risk of exposure. Vaccination against typhus is an

essential means for saving lives. There is some evidence also that while vaccination does not prevent infection, it does decrease transmissibility of infection by lice which have fed upon a vaccinated typhus patient. The use of the vaccine to control epidemics among civilians has been questioned. It is, however, of undoubted value in preventing loss of key personnel, as well as in saving lives generally, and it may lower the epidemic potential.

During 1943 the remarkable insecticide now known as DDT displaced the previous ineffective and impractical methods for controlling lice<sup>1, 9, 16, 31, 33</sup>. In contrast with the former cumbersome bathing establishments, steam and hot-air disinfestors, fumigants and ephemeral insecticides, which left the treated persons and their clothing vulnerable to reinfestation at the next encounter with lice, DDT killed body lice rapidly enough and had a residual effect, lasting as long as a month after application to clothing. In the form of a powder containing 10 per cent of DDT in pyrophyllite, it was easy to apply from 2-ounce shaker tins or by hand dusters or power-driven dusters, modified from agricultural types of sprayers. The methods of application of DDT powder to persons fully clothed<sup>32</sup>, as worked out chiefly by the Rockefeller Foundation Typhus Team in Algeria in collaboration with the Preventive Medicine Section of the Office of the Chief Surgeon of the North African Theater of Operation, were simple, effective, and agreeable to the recipient. They permitted the delousing of thousands by a few operators in a short time. Enormous quantities of DDT were produced in the United States within a year and tons of the powder were sprayed on refugees, displaced persons, and citizens in North Africa, Italy, Yugoslavia, Germany, Austria, Japan and Korea during the years from 1943 to 1946. Large and small outbreaks of typhus were promptly controlled, and an incalculable number of infections prevented.

The chief examples of the effective control of outbreaks of typhus among civilians in occupied countries during World War II were the epidemic at Naples<sup>12, 38</sup> during the winter of 1943-44, the outbreaks in Germany and Austria in the spring of 1945, and the wide-spread epidemic in Japan and Korea from December 1945 to May 1946. In each region a dangerous epidemic was quickly brought under control, removing the hindrance to military operations and saving the people from the ravages of a pestilence formerly regarded as an inevitable accompaniment of war and famine.

A complete program for typhus control derives from principles insisted upon by Chapin and others; namely, accurate knowledge of the situation, purposeful education and training, and full utilization of the best available means and measures

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for control. With respect to typhus, the elements of the program may be summarized as follows:

- I. Case finding, reporting and dissemination of information on the situation.
- II. Isolation of cases by removal of patients to hospitals or by putting a barrier of DDT around the patient by dusting his body, clothing, and environment.
- III. Contact delousing with DDT.
- IV. Mass delousing by dusting with DDT entire populations of cities or regions.
- V. Immunization, especially the vaccination of key personnel.
- VI. Establishment of a "cordon sanitaire" along border stations for inspection and delousing of refugees, repatriates and groups and individuals in transit.
- VII. Education of the people by posters, newspaper articles, talks, broadcasts and motion pictures; enlistment of the cooperation of the people.
- VIII. Training of personnel in typhus control methods.
- IX. Arrangements for adequate funds, supplies and transportation.

In this program of control of epidemic typhus the attack upon the louse vector is the primary aim. Hence, the use of DDT is the main factor. Indeed, some have expressed the opinion that the use of DDT alone will be sufficient to prevent and control typhus. While there is much truth in this statement, it is not complete. Each of the other measures is important during epidemics. In addition, both during epidemics and in seasons between epidemics, typhus fever can be held in check by operation of improvements in social and economic conditions as measured by adequate supplies of soap and food.

#### *Endemic Murine Flea-Borne Typhus*

Endemic or murine typhus was ten times as prevalent as epidemic typhus among United States military personnel during World War II. During the years 1942 to 1945, 603 cases were reported in soldiers<sup>30</sup>. Of these, 414 cases occurred in troops stationed in the endemic areas in the southeastern and southwestern regions of the United States, where most of the infection was acquired in towns adjacent to Army posts. Of the cases in troops overseas, 13 occurred in South and Central America and 176 in the Pacific Ocean area. As the disease was mild, with a low case fatality rate of 2 to 5 per cent, it had none of the serious implications of epidemic typhus. A vaccine against murine typhus was not used in the American Army, although the British typhus vaccine contained both

murine and epidemic types of rickettsiae. The control measures were directed against rats and their ectoparasites, chiefly the main vector, the rat flea, *Xenopsylla cheopis*.

The disease was of constant interest to military preventive medicine. As a result of surveys made during the war, its world-wide distribution was more clearly recognized than before. The proof of its existence in the Philippines<sup>39</sup>, for example, was a product of war-time research, and at present unofficial reports from Army laboratories in Japan indicate that murine typhus has been the most prevalent form of the disease in certain areas this year.

Murine typhus is of such great importance for civilian public health in the Southeastern and Southwestern states of this country that its control has become a major undertaking of the United States Public Health Service in collaboration with State departments of health. Since 1930, the number of reported cases in the United States has increased annually from 510 to a peak of 5,346 in 1944, since when the incidence has declined. While the number of cases has been increasing, the disease has invaded new sections of the Southeastern States and other regions of the country. Approximately 97 per cent of all cases have been reported from Alabama, Georgia, Florida, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. The remaining 3 per cent has been widely distributed. Concentrations of cases have occurred in Los Angeles County, California; Pulaski County, Arkansas; Norfolk area, Virginia; and in the New York City area. Statistics of the incidence of murine typhus fever in the United States from 1930 to 1946 are presented in Table III.

**TABLE III**

Murine Typhus Fever in the United States 1928-1946;  
Statistics from the U. S. Public Health Service.

Year	Cases Reported	Year	Cases Reported
1930	510	1939	2998
1931	332	1940	1882
1932	955	1941	2782
1933	2069	1942	3736
1934	1372	1943	4530
1935	1287	1944	5346
1936	1732	1945	5193
1937	2392	1946	3366
1938	2294		

To control the disease, extensive efforts have been made to get rid of rats, which are the reservoir of the infection. Rat-proofing of buildings and rat-poisonings have been applied with varying degrees of success. Among the rat-poisons, sodium fluoroacetate, so-called 1080, a product of war research, appears to be highly effective. Lately the attack has been directed also against the rat flea by dusting with DDT powder all reachable rat-runs,

burrows, and haborages, and areas of passage in which rats might collect DDT on their coats and carry it to their nests. The early evidence that DDT might be useful for this purpose came from incomplete field trials in Algiers and Dakar during the war, in situations where protection from plague as well as from murine typhus was desired. It is still too soon to evaluate the results, but the indications are that DDT dusting combined with rodent control is reducing the incidence of murine typhus in this country<sup>23</sup>.

#### *Scrub Typhus — Tsutsugamushi Disease — Mite-Born Typhus*

When the United States entered the war in the Pacific area in 1941 scrub typhus was vaguely identified with tsutsugamushi disease, or Japanese river fever, and was regarded as an interesting exotic disease of sporadic occurrence. Its importance from the military point of view was not appreciated until infections occurred in troops during the operations in New Guinea during the fall of 1942. In the following years, until the surrender of Japan in August 1945, it increased in importance and terror from New Guinea and adjacent islands to the Philippines and in Assam and Burma, particularly along the Stilwell or Ledo Road. During the years 1942 to 1945, 6,685 cases of scrub typhus were reported among American troops<sup>30</sup>: Of these, 5,718 occurred in the Southwest Pacific Area and 967 in the China-Burma-India Theater. The case fatality rate ranged from about 1 per cent to as high as 28 per cent.

Extensive field and laboratory investigations of scrub typhus were carried out. Many urgent problems were solved and permanent additions were made to scientific knowledge<sup>5, 24</sup>. The outbreaks came upon troops in the field and were provoked, as it were, by the placement of troops in certain types of terrain, such as areas of Kunai grass in New Guinea or the scrub or low-bush areas of Owi and Biak. Some combat units were rendered ineffective. General anxiety increased. In its effects upon troops and military operations scrub typhus was far more important than epidemic louse-borne typhus.

This disease is caused by a rickettsia called *R. orientalis* or *R. tsutsugamushi*. Its reservoir in the Southwest Pacific and in Assam and Burma appears to be chiefly field rats. The infection is transmitted by the larvae of trombiculid mites, especially *Trombicula deliensis*, and *Trombicula fletcheri*, a variant of *Trombicula akamushi*. In the mites the infection is transmitted by trans-ovarial passage, so that an area of ground colonized by infected mites may be widely and patchily "contaminated." Man is infected when the larval mite establishes its feeding tube in the skin of the individual to which it has become attached.

Neither the disease nor any known mite vectors of it exist in the United States. It is to be hoped that it will remain a disease of exotic interest to the inhabitants of this land. As long, however, as United States troops have to operate in certain regions of the Pacific areas, the disease will be of personal as well as military concern to our people.

No vaccine was available for immunization against scrub typhus. A vaccine made in England<sup>10</sup> from scrub typhus rickettsia obtained from the lungs of experimentally infected cotton rats came too late for extended field trials. The same may be said of scrub typhus vaccine made in this country at the Army Medical School and at other laboratories, including those of a manufacturing firm. There are indications, however, that these vaccines have promise of providing some degree of protection. If immunization ameliorated the disease and decreased the mortality, it would be a great gain.

Protection from attack by chiggers or red-bugs, the larvae of trombiculid mites, has been of interest to the people of this country for a long time. Common annoyance from chiggers brings the problem of control closer home. The results of intensified investigations made during the war to control scrub typhus by attack against mites will spread to civilian comfort.

Control measures against scrub typhus were worked out with difficulty in the field in New Guinea during 1943 to 1945<sup>6, 7, 8</sup>, and in this country through collaboration with the Bureau of Entomology and Plant Quarantine of the Department of Agriculture. Two basic principles laid down some 30 years ago by the United States Department of Agriculture were followed. These were (1) individual protection through wearing chemically treated clothing and (2) elimination of chigger breeding by chemical treatment or by changing the ecology of an area so that mites could no longer survive in the soil.

During the war the Australians established the fact that dibutyl phthalate was an effective laundry-resistant miticide when smeared by hand at the rate of one ounce over a uniform. Members of the United States of America Typhus Commission developed a simple and rapid means for impregnating uniforms by dipping them in an emulsion of 5 per cent dimethyl phthalate in 2 per cent solution of laundry soap. This method of treatment of uniforms was used successfully by American troops from the middle of 1944 until the end of the war<sup>6, 7, 37</sup>. It had the disadvantage of being temporary, as the dimethyl phthalate was leached out by rain, immersion in water and by laundering. Before the end of the war, it was found that benzyl benzoate was a more effective miticide and that uniforms impregnated with this compound re-

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mained miticidal even after two launderings with soap and water. Since then reports from the Bureau of Entomology and Plant Quarantine<sup>8</sup> indicate that benzil and dichlorodiphenyl are superior and more resistant to laundering than benzyl benzoate.

Application of sulfur dust, DDT and fuel oil were tried in area-control, to produce conditions unfavorable to the breeding of mites. Their effects were not satisfactory. Unpublished reports from the Bureau of Entomology and Plant Quarantine, presented by Bushland<sup>8</sup> at the AAAS Symposium in Boston in December 1946, indicate that hydroxypentamethylflavan and benzene hexachloride applied either as dusts or sprays, at dosages as low as 4 to 6 pounds per acre, may eliminate mites from an area for at least a month after treatment.

About twelve years ago Doctor Hans Zinsser<sup>42</sup> made this prophesy: "Typhus is not dead. It will live for centuries, and it will continue to break into the open whenever human stupidity and brutality give it a chance, as most likely they occasionally will. But its freedom of action is being restricted, and more and more it will be confined, like other savage creatures, in the zoological gardens of controlled diseases." During the World War of 1939 to 1945, both parts of this prophesy were fulfilled. Typhus reappeared in epidemics in the conditions produced by human stupidity and brutality. In the same period, however, human intelligence and cooperation in self-preservation produced and used the powerful new weapons which have subdued the disease. The accomplishments in the control of epidemic typhus during the war make a notable chapter in military preventive medicine. These gains are now available to civilian public health. They indicate that given the will and the means to apply existing knowledge, no country needs to suffer again from a devastating epidemic of typhus, and that this disease and its relatives may be reduced to minor causes of sickness.

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## CHANGES IN MEDICAL PRACTICE\*

*President's Address*

HERMAN C. PITTS, M.D.

The Author. *Herman C. Pitts, M.D., of Providence. President, Rhode Island Medical Society, 1946-1947. Former President of the American Cancer Society.*

IN this very short address this afternoon, I shall not attempt to suggest plans for the future betterment of the Rhode Island Medical Society in particular, or the medical profession in general. The future most certainly lies in the hands of the younger generation. Youth looks forward, while old age looks backward to methods of action and modes of thought that seem to him still worthy of present day consideration.

And so I claim the privilege of discussing why the medical profession of 47 years ago functioned as well as it did, and why we should still bear in mind some of the lessons that older generation can teach us.

Going far, far back beyond those very short 47 years, we find medicine gradually emerging from the age of augury, of priestcraft, of sorcerers and charlatans. A very few, very brilliant, really scientific minds had visions of what was to come. But the lack of instruments of precision kept their visions from becoming reality.

We can have little conception in this day of many microscopes what Jannsen's discovery in the early 1600's really meant. A whole new world was opened wide almost over night.

That didn't mean that the average physician treated his patients with any greater intelligence. The accumulating knowledge was only for the few and did not in any way affect the average man.

In the light of present day knowledge it is hard to understand what those old fellows contributed to the health of their communities. Certainly there was nothing scientific in their approach to illness. And yet if we could project ourselves backward say to the days of the 18th and 19th centuries. I am quite sure we would find that the physician then had a standing in the community, a position of authority that should be the envy of any of us today. They were given credit, of course, for a great deal they didn't know, just as we are now given credit for knowledge that would be super-

human. Yes, it seems incredible that during all those years of ignorance when medicine was groping toward the light, her disciples—the so-called doctors, could have been held in such high esteem. The very fact that they were makes it certain that by and large they did some good. Otherwise, they would have been thrown out lock, stock and barrel as they were in the capitol of Guatemala in 1541 when the practice of medicine was forbidden by law because of the deaths that dogged the footsteps of the one physician there.

If the early physician knew very little beyond the use of a few simples of minor value and the use of a lot of horrible concoctions of no value at all, wherein lay the dependence of the human race on their administrations?

Arthur Young in his notes on "Travels in France in 1789" suggests, I think, a reason when he says, "there is a great deal of difference between a good doctor and a poor one, but very little difference between a good doctor and no doctor at all"—implying that a good doctor even of those days helped his patient not by excessive and often harmful drugging, not by bleeding and emetics, but by wise dependence on nature—by giving a boost to the morale of the sick person and by careful regulation of diet and activities. In other words, in the absence of scientific medicine, he had developed the art of medicine. And the art lay then and lies today in the ability of the wise physician to so win the confidence of his patient that fears are allayed, the mind put at rest and the stage set for the recuperative powers of the body to do their part in restoring health.

No, I am not a Christian Scientist, but I do believe as Osler taught that when the body is sick, the mind is sick and unless the physician is able through art to restore the mind to proper functioning, the body lags behind in its recovery.

During my medical course we had a series of lectures by one of the deans of the profession in New Haven. I think of him as a handsome, gray haired gentleman in his late sixties. He talked on Medical Ethics and Medical Etiquette. I remember practically nothing of what he said. That could hardly be expected of one in the process of being stuffed with scientific knowledge, but I am quite certain we could have learned many useful lessons

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from that kindly gentleman's vast store of medical experience. How little the young man knows of the proper approach to private patients and how much he could learn from just such lectures if he had wisdom enough to listen! A case in point—Two different young men had occasion to do something for a patient of mine in Jane Brown Hospital on successive days. The first is a man of real ability—he knows medicine and the patient had to admit he was skillful—but she didn't like him. The second is good, but not quite up to the level of the first, and my patient liked him much better. I was interested to know her judgment of the difference between the two. "Well," she said, "the first man went at me without saying a word, without any greeting, without explaining what he had to do. He was coldly businesslike and left me feeling mine was just one of the many tiresome jobs he had to finish in a given time. The other came in with a smiling 'Good morning', explained somewhat of the reason for his visit and went away leaving me feeling like a real human personality." The first young man unless he changes, will always practice scientific medicine. He may be successful, but he will miss the great satisfaction that comes from having a following of very loyal, very devoted patients. On the other hand, the second young man, if he continues to mix a good measure of the Art of Medicine with what is scientifically sound, will find the satisfaction in his practice that will be denied the first.

As I saw the older physicians in the early days of my practice, they used the Art of Medicine to a very great extent. Their scientific knowledge as measured by present day standards was not to be compared with that of one of our recent graduates in medicine. And yet, by and large they did quite as much for suffering humanity through their acquired wisdom as the most brilliant of our graduates will be doing after 20 years in practice. They were dictatorial. Their attitude of authority, which no one of us of the present dares to assume, gave them such a tremendous standing in the minds of all people that I often think their patients got well because they were told they would!

I can very well remember several years ago meeting one of Providence's old dowagers on the street. She stopped me to ask if I could recommend a good medical man. I thought I knew several and mentioned their names. "Oh," she said, "I have been to every one of them and what do they do but tell me I must have my eyes examined, or an x-ray of my stomach, or my blood chemistry taken or some other perfectly foolish thing done when all I need is some good advice and encouragement and a little medicine. Since Dr. Gardner died, I haven't found anyone who has a particle of common sense. In the old days when I didn't feel well, I either went

to his office or he came to the house. I told my story. He asked a few questions. Then he would write a prescription or give me a few pills and say, 'Take this medicine for a few days and you will be well,' and sure enough—I was!"

I do not mean to advocate slipshod, careless methods of examination, but I am certain that Dr. Gardner's knowledge of human nature in general and the characteristics of the patient under consideration in particular, made it perfectly safe for him to treat her more by Art than by Science, to the saving of much time on his part and much expense on hers.

Again those older men relied much more on their senses than do we of the present day. This is a mechanical age and being such, I presume it is quite natural that the younger generation turns more and more to mechanical aids to diagnosis in illness. No one can gainsay their value—but for Heaven's sake let us train the senses God has given us and use them first and then if more help is needed, call in any and all of the gadgets that will be of any use. The cost of medical care has already risen to a point where the average man cannot afford the luxury of illness for himself and family. The too free use of mechanical aids steadily increases the cost and by so doing in turn increases the demand for State medicine.

I believe medicine will be kept on a surer footing if all physicians, and particularly our younger men who really hold the future of medicine in their hands, remember that there is room for Art as well as Science in the practice of medicine. Science deals with the pathologic aspects of illness; Art with the rather intangible thing called "morale" and the subtle effect of the mind on the functions of the body.

After all, the future of medicine depends very largely upon our relations with the public and the character of those relations rests in the hands of each and every one in the medical profession. If he—every individual physician—makes himself as proficient in the Art of Medicine as he must be in the Science of Medicine, there is no question but that the future of our great profession is assured.

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## THE MEDICAL EXAMINERS' PROBLEM IN RHODE ISLAND\*

ALBERT J. GAUDET, M.D.

The Author. *Albert J. Gaudet, M.D., of Pawtucket, R. I. Medical Examiner, District Eight, Rhode Island.*

I HAVE BEEN Medical Examiner of District 8 in Rhode Island—which covers Pawtucket and Central Falls—for about a year and a half. This constitutes my entire experience in medicolegal work, so it is quite obvious that I cannot be qualified as an expert in this highly specialized field. Accordingly, I feel quite brazen standing here tonight speaking to you learned gentlemen about Medical Examiners. However, I have done considerable reading on the subject and was exposed to an excellent seminar in legal medicine last October at the Harvard School of Legal Medicine where Dr. Alan Moritz and his associates conducted a very interesting and instructive course on the subject. My year and a half as Medical Examiner has been a very busy one—and I have had quite a variety of cases—all the way from simple unattended deaths to homicide. Because of my reading, my attendance at Harvard and my experience, I have developed a few ideas concerning Medical Examiners, their duties, and in particular, the failings of the law in Rhode Island. These ideas I would like to present to you tonight for your consideration.

I doubt if there is any public office in these United States that has more variable characteristics than that which I hold at present. The method of selection varies from state to state—election by popular vote, patronage appointment and selection based on ability and qualifications—one of these is the usual method. In Rhode Island, Medical Examiners are appointed by the Attorney General and hold office at his pleasure. The duties of the Medical Examiner also vary widely—all the way from the restrictive law of Tennessee which states that only when “there is good reason to believe that such person came to his death by unlawful violence at the hands of some other person”; or that of Michigan where an investigation is justified when “there is good reason to believe that murder or manslaughter has been committed”; to the quite adequate laws of New Jersey which I will quote a

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little later on. The law in Rhode Island is very vague and certainly is not adequate for the proper direction and protection of the Medical Examiner. This will also be enlarged upon a little later. Even the titles of the investigator vary from one state to another—for example, Medical Examiner, Medical Referee, Coroner, etc. It can be seen that there is no uniformity as regards the selection and duties of Medical Examiners. I realize that uniformity throughout the forty-eight states is not necessary for the proper and efficient discharge of this important office. However, adequate legal backing should support the Medical Examiner so that he can fully discharge his duties for the protection of the public welfare. Rhode Island is lacking in this respect and I believe this Society should initiate action for the correction of this evil.

The power and the duties of Medical Examiners in the State are prescribed by the provisions of Chapter 409 of the General Laws of 1923 and the Amendments thereto, plus a reference to the subject in section 6 of Chapter 166. Much of Chapter 409 deals with appointments—which we have already mentioned—records to be kept and submitted by the Medical Examiners—which could be improved upon—and the fees which the Medical Examiner shall receive. In Rhode Island, Medical Examiners are paid five dollars for viewing a body and twenty-five dollars for an autopsy. This in itself is an evil, for since the Medical Examiner's income is determined by the number of cases he handles, it is only natural that the public welfare is not his only consideration in determining which cases he shall investigate and “take over”.

Sections 8, 9, 10, 17 and 23 to 32 inclusive deal with the powers and duties of the Medical Examiner. Without going into too much detail, I would like to quote the pertinent parts of these sections so that you can understand my statement that the laws of Rhode Island are vague and inadequate. Section 8 provides as follows: “Medical Examiners shall make examinations as hereinafter provided upon bodies of such persons only as are supposed to have come to their death by violence; Provided, that in case any prisoner in the State prison or in any county jail dies while so imprisoned, it shall be the duty of the medical examiner of the district

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in which such prison or county jail is situated, upon being notified of the death of such prisoner, to make at once examination upon the body of such deceased prisoner."

This Chapter appears to be self-explanatory, except that the word "supposed" is very indefinite. The exact interpretation of this word has never been passed upon by our State Supreme Court. A definition is available from an Ohio Case—the case of the State of Ohio vs. Bellows. This definition states—"death is supposed to have been caused by violence when a dead body is found in the County, whenever, from such observation as the Coroner may be able to make, and from the information that may come to him, there is substantial reason for belief or surmising that death was caused by unlawful means." Now—as you can readily see—this is all very vague and non-specific. Even the broadest interpretation leaves much to be desired—for example—cases admitted to a hospital and who die within 24 hours of admission, cases of fulminating infection or insidious poisons which endanger the public welfare—these and other cases are not provided for under our present statutes.

Section 9 states: "When a medical examiner has notice that there has been found or is lying, within his district, the body of a person who is supposed to have come to his death by violence, he shall forthwith repair to the place where such body lies and take charge of the same; and if, on view thereof and personal inquiry into the cause and manner of the death, he deems a further examination necessary, he shall, upon being thereto authorized in writing by the attorney-general, or by the mayor of the city or president of the town where such body lies, make an autopsy in the presence of two or more persons as witnesses, and shall then and there carefully reduce, or cause to be reduced, to writing, every fact and circumstance tending to show the condition of the body and the cause and manner of death, together with the names and addresses of said witnesses, which record he shall subscribe. Before making such autopsy, he shall call attention of the witnesses to the position and appearance of the body. If such body be found at the residence of the deceased, a medical examiner shall not remove such body therefrom unless necessary for further examination or autopsy. Such examiner shall, after any required examination or authorized autopsy, promptly deliver or return such body to the relatives or representatives of the deceased, or if there are no relatives or representatives known to the examiner, he shall cause the body to be decently buried, except that such examiner may retain as long as may be necessary, any portion of such body necessary for the detection of any crime."

As you can see, this section gives the procedure to follow in those cases requiring autopsy. I have no

quarrel with the present Attorney General's Department in this regard, for I have had the fullest cooperation and have been allowed considerable latitude. However, the fact still stands that non-medical personnel, holding political offices, must give permission to the Medical Examiner before an autopsy can be performed. That this is an undesirable feature of our Law as it stands can hardly be refuted. I believe that if a Medical Examiner is qualified to carry out his duties properly, he should also be qualified to determine when an autopsy should be performed. No other permission should be necessary—and certainly it is not desirable.

Section 23 states: "If a medical examiner reports that a death was not caused by the act or neglect of some person other than the deceased, the attorney-general may, notwithstanding such report, direct an inquest to be held in accordance with the provisions of this chapter; at which inquest he, or some other person designated by him, shall examine all the witnesses."

This is a good feature in the law as it stands—for certainly the Legal Authorities should have the right to order an autopsy and an inquest even if the Medical Examiner is contrary minded.

Section 24 states: "The medical examiner may, if he deem it necessary, employ a chemist to aid in the examination of the body, or of substances supposed to have caused or contributed to the death; and such chemist shall be entitled to such compensation for his services as the medical examiner certifies to be just and reasonable, the same being audited and allowed in the manner hereinafter provided."

This section should be revised to include other experts such as photographers, ballistic experts, etc. Modern day medicolegal criminology requires the close cooperation of many experts—not just that of a chemist or toxicologist.

Section 25 and the amendment thereto, Section 2 Chapter 659, deal with the disposal of unidentified or unclaimed bodies. This section could stand revision for it leaves the door wide open for discreditable alliances between overseers of the poor and undertakers.

Sections 26 and 27 deal with recovery fees to be paid when a dead person is found in a body of water and with the disposition of valuables and property of the deceased. These Sections seem to be fairly adequate and, I believe, require little change.

There is nothing else in the General Laws to guide the Medical Examiner. Furthermore, there is nothing in the Law to guide the Attorney General in appointing Medical Examiners.

From what I have said up to this point, I think it is quite evident that the Law governing the duties of a Medical Examiner in Rhode Island are totally inadequate. Undoubtedly it is the intent of the



law not only that the true cause of death be established with the greatest possible precision but also that all evidence pertaining to the circumstances thereof be acquired. To attain the desired end of fulfilling the office of Medical Examiner for the best interests of the public welfare, "intent" is not sufficient. There must be adequate and clear laws to give the Medical Examiner every assistance in the proper and useful discharge of his office. In this respect New Jersey has a very good law—lacking only in two minor points. It states; "When, in the county, any person shall die as a result of violence or by casualty or suicide, or suddenly when in apparent health, or when unattended by a physician, or within twenty-four hours after admission to a hospital or institution, or in prison, or in a suspicious or unusual manner, the police department of the municipality in which he died, the superintendent or medical director of the institution in which he died, or the physician called in attendance shall immediately notify the office of the chief medical examiner of the known facts concerning the time, place, manner and circumstances of the death. Immediately upon receipt of such notification the chief medical examiner, or an assistant medical examiner, shall fully investigate the essential facts. If necessary he shall go to the dead body and take charge thereof." This law would be improved by the incorporation of a provision requiring medicolegal investigation of deaths of persons whose bodies are to be cremated, plus a more specific statement of "when unattended by a physician". I believe a specific time should be set, say "when unattended by a physician within one week of death".

As regards qualifications of officials responsible for the investigation of deaths in the interests of public welfare, much can be said. It is obvious that the law should require that the office of medical examiner be occupied by a physician. It is equally obvious that he should either be a qualified pathologist or be required to employ the services of a qualified pathologist for the performance of autopsies.

Whenever doctors are responsible for the establishment and maintenance of organized medical facilities for the care of the sick, provision is almost invariably made whereby a physician who is skilled in the science of pathology is made responsible for the performance of autopsies. Without in any way detracting from the importance of autopsies performed for scientific or educational reasons it should be pointed out that only when an autopsy is medicolegal is it likely to have an immediate and direct effect on the life, liberty or property of some person. On the outcome of a medicolegal autopsy may depend the life or freedom of a suspected person. On the outcome of a medicolegal autopsy may depend the indemnification of a widow or the

liability of an employer or an insurer. With such issues at stake it is strange indeed that only when an autopsy is performed in the interest of justice is it entrusted in many instances to some one lacking proper qualifications for its conduct.

To appraise the relative merits of the political and non-political methods for the selection of official medical investigators it is necessary to consider for a moment the nature of the public service expected of them. They function as scientific, fact-finding agencies. Incompetence or partisanship on the part of such an official may be responsible for the non-recognition of crime, for the non-prosecution of criminals, for the unjust prosecution of innocent persons and for miscarriage of justice in courts of civil law. Their functions are in no way policy forming.

There has been a growing recognition in this country of the fact that public servants whose duties are technical and not policy forming should be selected by different means than are employed for the selection of public servants whose duties include policy determination.

It is a fact that medical science participates less effectively in the administration of justice in the United States than it does in any comparable civilized country in the world. An important, if not the principal cause of this deplorable condition, is the fact that official medical investigators are selected in most states by political methods rather than by the merit system. The practice of selecting official medical investigators by direct vote of the electorate or by some form of political patronage has led to the systematic scrapping of invaluable experience, has placed persons in office who are not only inexperienced but not infrequently incompetent as well, has predisposed to partiality in the conduct of public business and has discouraged from entering public service the very kind of physician that should be engaged in this important type of work.

As regards specific suggestions as to changes in the present law—I think I can best cover this part of my talk by quoting from the report of the Committee of the A. M. A. to Study the Relationship of Medicine and Law—the report from which much of what I have already said has been taken. In reporting on model legislation the Committee has this to say, and I quote:

1—That the official investigator shall be responsible for determining the cause of death and such medical or other information from an examination of the body that may indicate the manner of death.

2—That it shall be the duty of a magistrate of a county or municipal court to hold an inquest if in the opinion of the official investigator or the county attorney such a procedure is indicated.

3—That it be stipulated that the official investi-

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gator shall be a qualified physician and that he shall be selected and retained in office under some form of the merit system rather than by political preference.

4—That the official investigator shall be notified when in his county (or jurisdiction) any person shall die of violence or suddenly while in apparent health or from obscure causes or when unattended by a physician or in any unusual or suspicious manner, or when in his county or jurisdiction the body of any dead person is to be cremated. Immediately on receipt of such notification the official investigator shall go to the place where the body lies and take charge of it. He shall then and there make a written description of the body and the premises, which report, together with an opinion regarding the cause and manner of death, he shall have copied and within seven days give one copy to the county attorney.

5—That, if in the opinion of the official investigator or the county or state's attorney it is in the interests of public welfare to perform an autopsy on the body of a person whose death occurs under the purview of the law, such an examination shall be performed or caused to be performed by the official investigator.

6—That an official autopsy may be performed by the official investigator if he is a qualified pathologist and, if not, the official investigator shall engage the services of a qualified pathologist for the performance of such an autopsy.

7—That the official investigator may, within the limits of the funds supplied his office by the county budget commissioner, engage the services of a toxicologist to assist in the investigation of the cause of circumstances of any death coming within his purview.

8—That there be created (for the benefit of communities not already supplied with such facilities) a state consulting laboratory having professional and technical facilities for assisting official investigators in the conduct of pathologic and toxicologic investigations on the bodies of persons whose deaths come under the purview of the law.

In concluding, I think it is safe to say that the ineffectual manner in which medical knowledge and skill are utilized in the Administration of justice in the State of Rhode Island undoubtedly predisposes to:

- 1—The nonrecognition of murder.
- 2—The unjust accusation of innocent persons.
- 3—The improper evaluation of medical evidence bearing on the circumstances in which fatal injuries were incurred.
- 4—Failure to acquire medical evidence which would be useful in the apprehension of criminals.
- 5—Failure to acquire medical evidence essential to the administration of civil justice.

6—Ignorance of certain otherwise preventable hazards to public health, and

7—The impairment of the value of vital statistics.

Finally, I believe that this Society and the State and County Medical Societies should initiate—and follow through to enactment—legislation that will correct the evils that now exist in the medicolegal laws of our fair State.

#### THE CONTROL OF TYPHUS FEVER

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#### CARE OF POST-OPERATIVE, CARDIAC AND ELDERLY PATIENTS

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# The RHODE ISLAND MEDICAL JOURNAL

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## THE MEDICAL EXAMINER SYSTEM

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ELSEWHERE in this issue is an article entitled, "The Medical Examiners Problem in Rhode Island," written by a medical examiner. At a recent meeting of the House of Delegates of the Rhode Island Medical Society, without cognizance of this article, a committee was appointed and the Rhode Island Bar Association was requested to appoint a cooperating committee for the purpose of studying and making recommendations concerning the Medical Examiner System in Rhode Island.

It is fitting that the physicians of Rhode Island should be interested in the Medical Examiner System. If medicine is able to contribute to legal procedure and to the promotion of law and order then all doctors should be concerned with the machinery designed to accomplish this. Whether or not the system offers the greatest possible help and protection to the public is of first importance. Whether or not it is carried out in a way that affords satisfaction and credit to the physicians who act as medical examiners and to the medical profession of our state is also a legitimate concern.

For many years we have heard criticism of and expressions of dissatisfaction with the Medical Examiner System. These have come from medical examiners, from other physicians, from judges and lawyers, and from nonprofessional people. There seems to be an impression that the system is not so good as it might be. Much of this, however, is based upon assumption and hearsay. We are un-

aware of any systematic study designed to collect factual data concerning all details of the system. The report of Mr. Bruce Smith, made about two years ago for the Rhode Island Public Expenditure Council, centered largely upon the qualifications of medical examiners to make postmortem examinations. While this is important it is, in our opinion, a very small part of the problem and one that can be readily improved.

Study should include the method of selecting and appointing medical examiners. It seems obvious that merit rather than political expediency should be the basis of selection and that tenure of office should be for long terms and should not be endangered by political changes. Perhaps appointment by a nonpartisan commission from doctors nominated by the local medical societies, as is now the method in Virginia, might be desirable.

The method of compensation might be worthy of study. Possibly the present fee system is not best from the standpoint of either the public or the medical examiner.

The authority of medical examiners needs to be defined. It is undesirable that in medical fields they should be subject to being overruled by political or legal officials.

The duties of medical examiners should be defined. As we see it, their duty is to investigate all sudden, unexplained or suspicious deaths in order to determine whether or not there is reason to

*continued on next page*

suspect legal complications. In many cases this investigation will not reveal any indication for a postmortem examination. We suggest that when the medical examiner does decide that a postmortem examination is needed, he is entitled to and should be required to have the assistance of experts in pathology and toxicology. This would place upon the state responsibility for furnishing such experts as well as the necessary laboratory space and equipment.

Careful study of all aspects of Rhode Island's Medical Examiner System by the medical and legal groups should bring out the strong and the weak points of the system and suggest ways of strengthening the weaknesses.

### PHYSICIANS HONORED

The more esoteric members of our profession, the internists, have just been foregathering at the annual session of the American College of Physicians at Chicago. Progress in Internal Medicine has been truly phenomenal in the last ten or fifteen years, and the impressive program dealt with many subjects unknown to the well-informed doctor of two decades ago.

Rhode Island has an enthusiastic group of members who were well represented there. Dr. Alex M. Burgess, Governor of the College from this state for several years, ended his term of office and has a worthy successor in Dr. Herman A. Lawson. Dr. Lawson's qualities as an administrator are as well recognized as his clinical abilities. He showed that when as Colonel he headed the Rhode Island Hospital Unit in India. Added confirmation is now given by his appointment to the Board of Hospital Commissioners of Providence.

But the College has not lost the services of Dr. Burgess's guiding hand. He has been advanced to the position of Regent. Each year five of these are appointed to serve for three years. Naturally, the men holding these positions are usually from the great teaching centers. They dwell a little apart from the mass of physicians; their viewpoint is necessarily not just that of the man whose career is centered on practice, not education.

Dr. Burgess coming from a progressive community, but one well away from a medical school, will supplement and broaden the services of these leaders of the profession. His work among us has shown how well equipped he is to do his part. We are pleased that our community can contribute so much to the work of the American College of Physicians.

### ANNUAL MEETING

Once again our Annual Meeting can be described by that much abused American slogan, "Bigger and Better." When we arrived a bit late at the opening of the meeting, several dozen members were standing in the rear, and there was one empty seat in the entire hall. We were about to take this when

we realized that if we did the visiting speaker would have no place to go at the conclusion of his address. Many late applicants were unable to get reservations for the Annual Dinner. Every niche and cranny on the three floors of the Library were filled with the technical exhibits. So much for the bigness.

It would really be unfair to say that this meeting was better than its immediate predecessors, but it is saying a lot when we note that it maintained the high standard to which we are now accustomed. In one respect there was a decided improvement. The Chapin Oration was delivered at the scientific session in the afternoon, and the delightful ceremony of the presentation of the medal given by the City of Providence, took place as part of the post-prandial exercises at the hotel. Mr. Frederick S. Barnes of the City Council was signally graceful in his presentation speech.

Before this, Governor Pastore addressed us. The highlight of his talk was his discussion of the Medical Examiner problem in Rhode Island and his pledge of help in improving the present unsatisfactory setup. The members of the Rhode Island Medical Society have been greatly impressed by Governor Pastore's understanding of some of our problems and his sympathetic desire to help us solve them.

Although out-of-town physicians from even as far away as Dixieland predominated on the program, Drs. Fulton, Hamlin and Pitts demonstrated ably that instruction and inspiration could come from our own ranks. We congratulate Dr. Pitts on a year of great achievement culminating in a wonderfully satisfactory Annual Meeting, and we look forward to another similar year under the leadership which Dr. Ruggles has long shown us he can give.

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**WHEREAS**, The articles entitled "Your Health" written by Dr. Peter Pineo Chase and published in local newspapers, have received well-deserved praise from the medical profession and the laity alike.

**WHEREAS**, These essays, together with the question and answer columns, have been composed in easily comprehended language, often compared with conditions well understood by the reader and characterized by a dry humor which has made them both interesting and readable.

**WHEREAS**, This column is of great value in assisting the educational work of the Rhode Island Medical Society in making disease and its treatment more easily understood by the layman.

**THEREFORE, BE IT RESOLVED**, That the Rhode Island Medical Society express its approval of these articles and its hope that Dr. Chase will continue the educational program so auspiciously begun.

—Adopted by the House of Delegates of the Rhode Island Medical Society, May 7, 1947



## "HOME TOWN" MEDICAL CARE FOR THE VETERAN

IN THE FALL of 1946 a committee of the Rhode Island Medical Society began its conferences to formulate a fee schedule to be the basis for a contract between the Veterans Administration and our Society for out-patient care of veterans with service-connected disabilities. This is the "Home Town" plan which has received much publicity with emphasis on free choice of physician by the veteran. It should be made clear, however, that in actual practice the veteran will have no choice of physician except under unusual circumstances. In Rhode Island veterans must go to the existing V.A. facilities for treatment. This matter became an issue between the Ohio State Medical Society and the Veterans Administration, and as a result it was made clear by General Bradley that veterans must go to such facilities except when it might be impossible for exceptional reasons. It is not our purpose to quarrel with this policy. It has merit. Hospitals and clinics that have been set up at great cost, are well-equipped and staffed by competent physicians should be utilized as a matter of economy if for no other reason. We do oppose, however, misleading publicity. If there is, in general, to be no free choice of physician it should be so stated with all reasonable defense of such a policy.

The Committee of the Rhode Island Medical Society prepared a fee schedule with considerable thought and with conscientious effort to make it fair, reasonable and in accord with fees charged the average patient in this community for similar services. This fee-schedule was submitted to the House of Delegates at its January meeting. It was approved by this body and forwarded to the Veterans Administration which refused to approve any fees which exceeded the maximum allowed by the V.A. fee schedule. In other words, although the Rhode Island Medical Society had been asked to prepare a fee schedule, such a schedule would be acceptable to the V.A. only if it conformed to one already prepared, presumably by authorities in Washington. Under the circumstances one naturally wonders why such a request was ever made to the Rhode Island Medical Society.

Moreover, the authorities propose to set up a fee schedule which shall be uniform and apply to every section of this great country of ours. This is a mistaken policy since it fails to take into consideration the necessary and inescapable differences in fees which result from the difference in overhead

expenses of physicians in varying sections of the country. Obviously, a physician in a large city, with heavy expenses, cannot afford to offer services for the same fee which might be adequate to a physician practicing in a small town in rural areas.

Other state medical societies are presently engaged in a controversy with the V.A. in regard to fees. In the Erie County Medical Bulletin, which is published by the Medical Society of the County of Erie and the Buffalo Academy of Medicine, this controversy is discussed in detail. That society had a fee schedule in force which had been accepted by the V.A. It has now been asked by the Veterans Administration to amend it so that it will conform to the fee schedule devised by the Washington authorities. "The Medical Society of the County of Erie intends to defend with every honorable means at its command the existing medical care fee schedule," in the state of New York, "as being in the best interest of veterans as a group."

Within a few days the Secretary of the Rhode Island Medical Society has received a copy of a communication to General Hawley signed by the Presidents of the Colorado, Montana, New Mexico, Utah, and Wyoming State Medical Societies. A paragraph from that communication is quoted:

"The undersigned officers of the state medical societies and associations of the Rocky Mountain States are therefore shocked to have received within recent weeks evidence of a complete reversal of the previous announced policy of the administration which recognized necessary regional differences in fee levels. There have been presented to the contracting bodies in these states so-called maximum fee schedules reputedly prepared in your Washington offices, and sent to the contracting states with letters to the effect that existing schedules must be revised so that all fees currently above these newly stated maximums must be reduced to that level but that no fees lower than these maximums may be increased. Such action was obviously taken without any previous consultation with the organized bodies representing the medical profession and without any consideration of the problems of practice within the areas concerned. It is the considered opinion of each of the undersigned that this new policy will completely wreck the home town plan for the care of veterans with service connected disabilities in the Rocky Mountain Region. We are not prepared to comment upon its effect elsewhere in the nation other than to emphasize that it is obviously unfair.

"It is the earnest hope of the undersigned that the recent action has been taken by some branch of your administration through misunderstanding and that we may soon have an authoritative statement clarifying this situation and again recognizing existing differences in fee levels throughout the varied regions of the United States."

We feel that this policy of the V.A. should be brought to the attention of all members of the

*continued on next page*

Rhode Island Medical Society who should give it their very thoughtful consideration.

Those who understand medical problems realize the great importance of finding solutions to problems which differ according to local situations. They realize the fallacy of attempting to set up complete uniformity throughout this great country of ours. The V.A. should realize that the membership of the Rhode Island Medical Society, and all state medical societies throughout the United States, is made up of a body of useful, intelligent, trustworthy citizens. The physicians of the United States are interested in governmental economy. They are just as much appalled by federal spending as any other citizen, since they are also tax payers. They realize, however, the serious mistake which unwise economy in medicine can be. They know that there is but one inevitable result of the payment of inadequate fees, and that is a lowering of the quality of medical care. The opinions of physicians should receive at least equal consideration, if not greater consideration, than the opinions of perhaps well-intentioned but misguided reformers and those bureaucrats who can never free them-

selves of the constant thinking in terms of jobs and political expediency.

The physicians of the Rhode Island Medical Society are interested in the welfare of veterans also, since a large number of them are veterans of the most recent World War and World War I as well. And a large number of them, in addition, have sons and even daughters who are veterans and whose welfare is a matter of great concern to them.

This type of medical care of veterans is indeed a form of state medicine. Here is an example to teach us what we can expect under such a system. Apparently officials in Washington will not hesitate to break contracts, and to dictate in an arbitrary fashion, to put in force impractical and unwise policies, and ultimately to destroy the morale of physicians and to lower the level of excellence of medical practice in this country.

"To everything there is a season, and a time to every purpose under the heaven." Now is the time for physicians throughout this country to oppose such arbitrary, unwise, and impractical policies, and to join in full cooperation in opposition to the menace of dictatorship.



Mrs. Jesse P. Eddy, 3rd, treasurer; Mrs. Herbert E. Harris, president; Mrs. Guy W. Wells, vice-president, and Mrs. Charles L. Farrell, secretary, (left to right) after their election at the annual meeting as officers of the Woman's Auxiliary to the Rhode Island Medical Society.

## WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

## — Report of First Annual Meeting —

THE FIRST ANNUAL LUNCHEON meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held on May 5, 1947, at the Plantations Club. Mrs. Herbert E. Harris, president of the Auxiliary, called the meeting to order at 1:00 p. m.

Dr. Herman C. Pitts, president of the Rhode Island Medical Society, was the first speaker. Dr. Pitts said that there should be better acquaintance among the wives of men who are trying to guide medicine in Rhode Island. He also hoped that we would help guide public opinion, and aid the medical profession in accomplishing its objectives.

Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, the next speaker, said he was looking forward to a great deal of support from the Woman's Auxiliary.

Mrs. James R. Miller, president of the Connecticut Woman's Auxiliary, extended greetings from Connecticut.

Mrs. David Allman, first vice-president of the Woman's Auxiliary to the American Medical Association and chairman of the National Auxiliary organization, spoke on the work of the Woman's groups throughout the country. She welcomed the Rhode Island Auxiliary into the National Society.

Following a delightful luncheon, a business meeting was held.

Mrs. Charles L. Farrell, secretary, read the minutes of the previous meeting. Mrs. Francis Hanley moved that the report be accepted as read. Mrs. Thomas Dolan seconded the motion. The motion was carried.

Mrs. Jesse P. Eddy, III, treasurer, reported that there was a balance on hand of \$450.00. Mrs. Robert T. Henry moved that this report be accepted. It was seconded by Mrs. Marden G. Platt, and the motion was carried.

The Vice-President, Mrs. Guy W. Wells, gave her report. Mrs. Marden G. Platt moved that the report be accepted. The motion was seconded by Mrs. William S. Nerone.

The vice-president took the chair, and Mrs. Herbert E. Harris, president, read her report. It was moved by Mrs. Frank M. Adams, and seconded by Mrs. Frank Dimmitt, that the report be accepted. The motion was carried.

The president resumed the chair.

Mrs. Thomas Dolan, chairman of the Nominating Committee, reported for her committee. The Nominating Committee had been instructed at the previous meeting to present as its slate of candidates the temporary officers of the Auxiliary, and its temporary Board of Directors. The secretary read the names of the officers and Board of Directors now in office.

The president stated that the Convention of the Woman's Auxiliary to the American Medical Association would be held in Atlantic City from June 8-12. She asked the members to elect delegates to the Convention from those planning to attend. One delegate could be elected for each 100 members or fraction thereof, and inasmuch as the Auxiliary has 176 members, two delegates besides the president should be elected.

A motion was made by Mrs. J. Murray Beardsley to accept the first two nominees with the greatest number of votes as delegates, and the next three as alternates. This motion was seconded by Mrs. Paul Cook. The motion was carried.

Mrs. Charles F. Gormly reported for the tellers as follows: Mrs. Charles Ashworth, 38 votes; Mrs. Charles L. Farrell, 35 votes; Mrs. Francesco Ronchese, 33 votes; Mrs. Jesse P. Eddy, III, 22 votes; and Mrs. Henry V. Moor, 18 votes.

Mrs. Charles Ashworth and Mrs. Charles L. Farrell were elected delegates. Mrs. Francesco Ronchese, Mrs. Jesse P. Eddy, III and Mrs. Henry V. Moor were elected as alternates.

The president then asked for nominations of candidates for the Nominating Committee for the next annual meeting. She also informed the members that the Constitution required that two members be elected from the Board of Directors and five members from the floor.

The following candidates were nominated: Mrs. Paul Cook, Mrs. Earl Mara, Mrs. Russell Hunt, Mrs. Elihu Wing, Mrs. J. Murray Beardsley, Mrs. Francis Hanley and Mrs. George Waterman.

It was voted to close the nominations.

The president then asked that the motion to close the nominations be rescinded in order to permit further nominations from the various districts of the State.

Mrs. Russell Hunt voted to rescind the motion

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## AMEBIASIS IN A RHODE ISLAND CHILD\*

HERMAN B. MARKS, M.D.

The Author. *Herman B. Marks, M.D., of Providence. Member, Visiting Staff, Department of Pediatrics, Rhode Island Hospital; Consulting staff, Emma Pendleton Bradley Home; Assistant Medical Director, Providence Child Guidance Clinic.*

**A**MEBIC DYSENTERY is presumably a rare disease in Rhode Island. The following review represents the first known reported case of amebiasis in a child in this state and seems, therefore worthy of report. While the disease has occurred only sporadically in Rhode Island, we may expect that cases will be reported more frequently in the next few years. The return of veterans from war zones where the disease is endemic and the practice of importing into the state domestic help from the Southern States and from Puerto Rico should serve as a reminder to include this disease in the differential diagnosis of any ill defined chronic gastrointestinal disturbance.<sup>1</sup>

Amebic dysentery has been reported in every state and should by no means be considered as strictly a tropical disease. Estimates as to the incidence of *Endamaeba histolytica* infections in the general population of the United States range from ten per cent by Craig<sup>2</sup> to twenty per cent by Faust<sup>3</sup> of the total population. It has been said: "Amebiasis is a common disease in the South." "Other surveys have suggested that it is only less common in the North and West as well."<sup>4</sup>

How much amebic dysentery have we had in Rhode Island? To answer this question a check was made of the records of:

1. State Division of Communicable Diseases.
2. Health Department of the City of Providence.
3. The Laboratories of the State and of the Veteran's Administration in Providence.
4. Five hospitals—Rhode Island Hospital; St. Joseph's Hospital; Charles V. Chapin Hospital; Homeopathic Hospital; Memorial Hospital, Pawtucket, Rhode Island.

It was felt that a study of the records of the above listed institutions and departments would give a fairly representative picture of the incidence of amebic dysentery in this state. A total of

\*From the Providence Child Guidance Clinic and the Emma Pendleton Bradley Home.

twelve cases were discovered. The following table shows the incidence from year to year.

Year	No. of cases
1929 .....	1
1931 .....	1
1933 .....	2
1934 .....	3
1940 .....	1
1945 .....	1
1946 .....	3

If one were to draw any conclusion from these figures, it would be that we have very little amebiasis in Rhode Island. These figures do not coincide very well with the previously quoted incidence of 10 to 20% for the general population. It should be emphasized that 76.2% of all cases are totally asymptomatic carriers and that careful fecal examinations would probably reveal a higher incidence of cases. Writing on the amebiasis problem, Craig<sup>5</sup> states dogmatically: "Routine fecal examinations are probably more important than routine blood examinations." While we might theoretically argue the relative merits of routine blood examinations vs. routine fecal studies, no one would disagree with Craig when he says, "If such routine examinations were properly made, more cases would be picked up and eliminated if properly treated." Since the great majority of infections in this country are acquired through food handlers, any rational approach to this problem should require careful stool studies for asymptomatic amebiasis in individuals so employed.

### Case Report

The patient is a 4½ years female child. Her symptoms began in December 1943 when she was 16 months old. The parents dated the onset of her symptoms from an episode which happened about that time. She was left alone with a baby watcher and when the parents returned a large black and blue mark was noticed on the bridge of the child's nose. How the child received this injury was never satisfactorily explained. It was shortly after this incident that the little girl began to have severe night terrors, 2 to 3 times every night. These night terrors would begin with grinding of the teeth and would culminate in loud screaming which her parents were unable to control. At about this time, she began to vomit frequently. Vomiting would

*continued on page 444*



# constipation



## in Ulcer Management...

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—Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 199.

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**SEARLE** RESEARCH IN THE SERVICE OF MEDICINE

## AMEBIASIS IN A RHODE ISLAND CHILD

*continued from page 442*

occur during or after a meal. It was at this time the mother noted small amounts of blood in the stool on several occasions. In April 1945, when she was 2½ years old, the child began to have very loose bowel movements. The stools would vary in number from 2 to 4 daily and were at times explosive in character. There were periods of no diarrhea during which the child would have very large formed stools which were unusually foul smelling. Along with the onset of the diarrhea, she began to have abdominal pain. She was treated with atropine which seemed to relieve the pain, but the diarrhea became worse.

By the time the patient was 2½ years old she had become an irritable child. This irritability became a constant feature of her personality pattern. She had to be removed from a nursery school because of her frequent vomiting. During the last 3 months—that is, October, November, December 1945—her vomiting, night terrors and irritability had become much worse. All attempts to discipline the patient had been ineffective.

The family consisted of the patient, her baby brother who was 2½ years younger, and her parents. The parents were young, intelligent, and cooperative. They were somewhat overwhelmed and discouraged by the persistence of their daughter's symptoms despite prolonged and very adequate medical study.

In December 1945 the patient was carefully studied in a children's hospital outside of Rhode Island. After a complete work up including G.I. series and intravenous pyelograms no organic factor could be found to explain the symptoms and the following diagnosis was made. "Behavior Problem with Emotional Instability 043-x72." It was recommended that the child should be seen by a child psychiatrist. Accordingly, the patient was referred to the Providence Child Guidance Clinic where she was started in therapeutic interviews on a weekly schedule.

In March 1946, I examined the patient for the first time because of a mild upper respiratory infection. The striking sign on physical examination was a markedly distended abdomen which was in marked contrast to the spindly arms and legs. These physical findings together with the history, of a chronic intestinal disturbance, large foul smelling stools, alternating with diarrheal stools, the picture of prolonged irritability,—all seemed to fit with the symptom complex of coeliac disease.

The following day, a stool specimen was examined for microscopic fat. No excessive amounts of fat globules were found. However, on microscopic study an unusual number of red blood cells were

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noted. This prompted further study and several cells were seen which looked suspiciously like trophozoite forms of *Endamoeba histolytica*. Several of these showed ingested erythrocytes.

During the next few days a series of fresh stool specimens were studied. Motile vegetative forms of *Endamoeba histolytica* were found. In 3 consecutive stools, using the zinc sulphate flotation technique, encysted forms, clearly differentiated from *Endamoeba coli* were demonstrated. It was therefore concluded that a diagnosis of Amebiasis was established and specific treatment should be instituted.

The patient was started on Tablets Chinioform 0.25 gms. t.i.d. This treatment was kept up for 10 days. Within 72 hours after instituting treatment there developed a most dramatic improvement. The night terrors disappeared; there was no further diarrhea. For the first time in many months, the child began to display vigor in her play. Her appetite improved, her irritability lessened, and she began to gain weight. Her abdomen remained distended. This consistent improvement continued through the next six months. She gradually gained weight and strength. It was some source of satisfaction to the parents that for the first time in her life this child was strong enough to pedal a bicycle.

Throughout this period, the patient and her mother made regular visits to the Providence Child Guidance Clinic. From almost her first interview, this child presented a picture of an emotionally disturbed girl with many difficulties in her relationship with her parents and her younger brother. The rapidity with which this child became involved in a relationship with the therapist and the intensity of this relationship was an indication of the extent of her emotional disturbance. In a long series of play interviews, she utilized this relationship to project her feelings about herself, her parents and her brother. As she brought her aggressive and hostile feelings to the surface in the presence of a sympathetic and supporting adult, many of her anxieties were dissipated. A very subtle but definite improvement in behavior was observed by both parents and clinic staff. This change in personality pattern is not too well delineated in this case report, but it was very real to those who followed this child's progress from week to week over the course of several months.

In November 1946, there was a slight recurrence of diarrhea and the patient was noted to be somewhat irritable. Physical examination was negative except for a mild degree of abdominal distention. Laboratory studies showed a mild degree of secondary anemia (Hemoglobin 10.5gm.). Stools were negative for trophozoites and cysts. She was given another course of treatment. This time, tak-

*continued on page 446*



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**INDICATED** in the treatment and prevention of hypochromic anemias; especially valuable in patients intolerant to other forms of iron.

**DOSAGE:** Average dose for adults is three to six (5 gr.) tablets; for children, one to four (2½ gr.) tablets or one to four teaspoonfuls of elixir daily.

**SUPPLIED** as 0.325 Gm. (5 gr.) tablets, bottles of 100, 500 and 1000; 0.163 Gm. (2½ gr.) tablets, bottles of 100; 5% elixir, bottles of 6 and 16 fl. oz.

Frederick Stearns & Company  
Division

1. Editorial: J. A. M. A. 127:1056, 1945

2. Moore, et al: J. Clin. Investigation 23:547, 1944

3. Reznikoff and Goebel: J. Clin. Investigation 16:547, 1937

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## AMEBIASIS IN A RHODE ISLAND CHILD

*continued from page 444*

ing Tab. Diadoquine gr. 3.2 b.i.d. for a period of 3 weeks. The mild symptoms disappeared, her appetite improved and her steady weight gain continued.

During the past year except for mild whooping cough and chicken pox she has enjoyed excellent health. She attends nursery school and is a healthy happy child.

## DISCUSSION

Although there was dramatic improvement in the patient's behavior following specific treatment for the amebiasis, it became quite apparent, as the interviews progressed, that this child's physical illness and emotional problems were interrelated—and to treat one phase of her illness and to neglect the other would not have produced the end result that we sought to achieve—a physically healthy, emotionally well integrated little girl. It is an accepted fact that physical disease can adversely affect the personality pattern of an individual and conversely, it is equally true that emotional maladjustment can accentuate somatic complaints. During the past 2 decades, these concepts have grown into the science of psychosomatic medicine. Obviously, had this child received psychotherapy alone (as was originally planned) her symptoms would have continued. Conversely, to have treated the amebiasis without giving consideration to the emotional conflicts that were engendered in both parent and child by this chronic disability would not have resulted in the complete and satisfactory results which were achieved.

The psycho-therapeutic aspects of this case are too complex to be reviewed in detail in this report. Suffice it to say, that the dynamic factors involved were not at all minimal. They colored the child's symptoms to a great extent and grew out in large measure from the fact that she was physically ill over so long a period.

The source of the infection has never been satisfactorily explained. It is known that there has been a series of maids in the home. One of these may have been a carrier. It is also known that the patient visited her grandparents, who live in the South, several times before the symptoms began. Stool examinations of the parents have been reported as negative.

It is noteworthy that the patient presented so many of the clinical features of the celiac syndrome. True celiac disease is relatively rare and many chronic gastro-intestinal disturbances in children of diverse etiology may simulate it. Chronic-intestinal allergies, parasitic infestations (including amebiasis), diseases of the pancreas—such as fibrocystic disease are but a few of the factors that may produce a clinical syndrome that may resemble celiac disease.<sup>6</sup> In fact celiac disease

was the clinical impression which first suggested itself in this case and it was a search for fat globules in the stools (a now outmoded laboratory procedure) which led to the accidental finding of the vegetative forms of *Endamoeba histolytica*. This fortuitous accident emphasizes the value of careful routine stool examinations.

## Summary

Amebiasis does occur in Rhode Island. Careful stool examinations performed more frequently would probably reveal a greater number of cases than are now being reported. The case presented is thought to be the first known case of amebiasis in a child in this state. Treatment involved not only eliminating the protozoa from the patient's gastrointestinal tract but also, and equally important, was concerned with the improving of the faulty parent-child relationship brought on by this chronic disability.

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## Acknowledgments

1. Dr. Gertrude Muller, Medical Director of the Providence Child Guidance Clinic supervised the psychotherapy of this case.
2. Dr. Eric Denhoff, Director, Clinical Laboratory, Emma Pendleton Bradley Home aided in confirming the laboratory diagnosis of *Endamoeba histolytica*. All laboratory studies were made at the Clinical Laboratory of the Bradley Home.

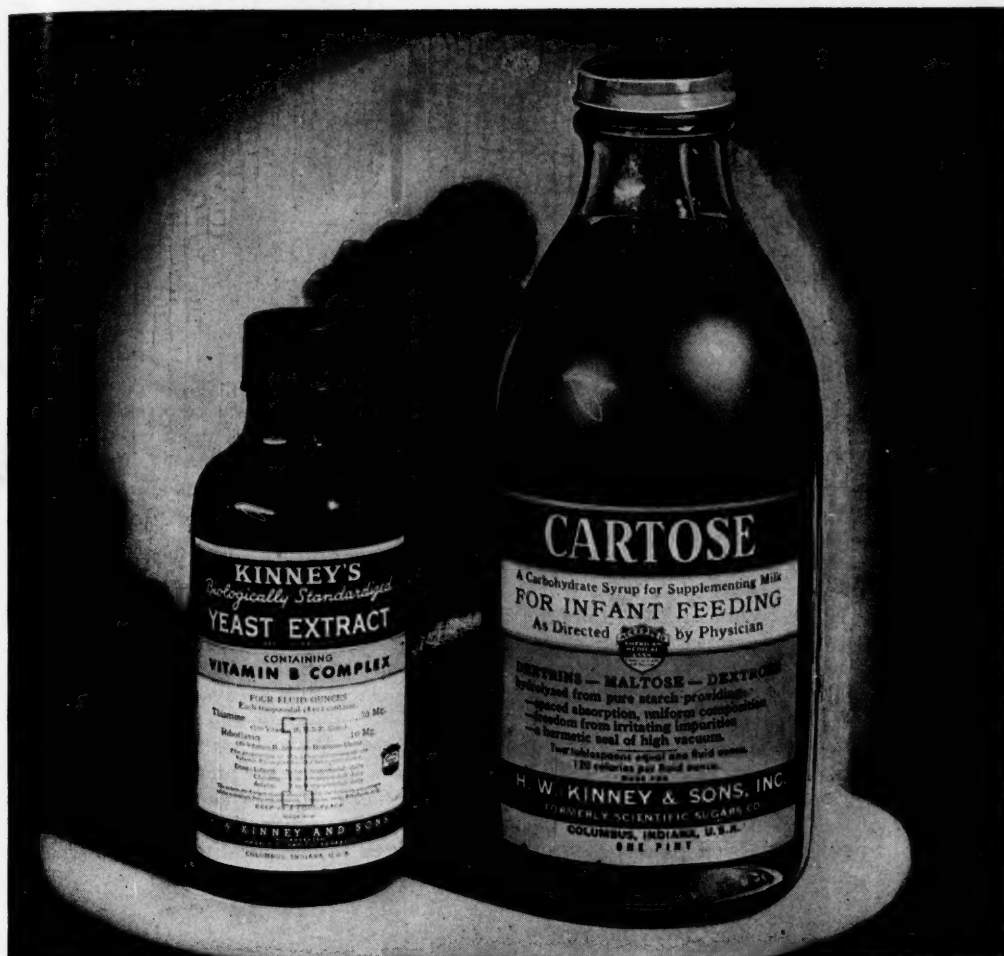
## CONGRESS ON OBSTETRICS AND GYNECOLOGY

The third American Congress on Obstetrics and Gynecology will be held at the St. Louis Municipal Auditorium, September 8-12. Physicians desiring to apply for membership should file requests now with the American Committee on Maternal Welfare, Inc., 24 West Ohio Street, Chicago 10, Illinois. The membership fee is five dollars.

The morning sessions of the Congress will be joint gatherings for everyone while the afternoons will be given over to separate group meetings, and round table discussions.

It is the aim of the Congress to provide a meeting that will be of value not only to the obstetric-gynecologic specialists but to those who come in contact with the greatest possible number of maternity cases, the general practitioners. The program will attempt to analyze, correlate and broaden the working contact of the doctor, the obstetric nurse, and the public health worker.





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## — THE ANNUAL DINNER —

*136th Annual Meeting of the Rhode Island Medical Society*

May 14, 1947

FRANK T. FULTON, M.D., *Presiding*  
 Anniversary Dinner Chairman

**Y**OUR EXCELLENCY, Governor Pastore, Honorable Frederick S. Barnes, Distinguished Guests, Fellows of the Rhode Island Medical Society, and your Guests:

A part of our program tonight is to pay tribute to the name of one of the great men of our profession, a native of Rhode Island, a man not long since dead, but who has left a name that we all like to honor. Dr. Chapin finished his medical education and his hospital training in New York in 1880, came to Providence and engaged in practice for four years, then became health officer in the City of Providence, a position which he held until his resignation in 1932, a period of 48 years—a long time for any public health officeholder. He was so far ahead of his time in his ideas concerning contagious disease that for years he was not particularly happy in his work, because of lack of co-operation both of the public and the medical profession. It was 26 years after he became health officer that the City Hospital

was built. I know it was a great satisfaction to him when the City Hospital was completed, where he could put to trial his ideas about contagion. This hospital under his direction soon became recognized as the model hospital for the modern treatment of contagious disease. Because of the distinction which Dr. Chapin had attained, the name of the hospital in 1931 was changed from the City Hospital to that by which you now know it.

Dr. Chapin's contributions benefited not the City alone, but naturally the State shares equally in these benefits which came from his distinguished efforts as a health officer. It is always a pleasure and satisfaction to have the State and City officials present at our functions. We look to them for support in all our efforts to improve the practice of medicine and sanitary affairs. In this Governor Pastore has shown active interest. He has graciously consented to be with us as our guest tonight and will now speak to you.

HONORABLE JOHN O. PASTORE  
 Governor of the State of Rhode Island

**M**R. TOASTMASTER, Reverend Member of the Clergy, Dr. Bayne-Jones, the recipient of the Award, Officers and members of the Rhode Island Medical Society and their ladies. First of all, I want to apologize for coming in here at a late hour, and not being able to stay to the conclusion of the exercises this evening. As your Toastmaster has already told you, I have been to one banquet, and I have to attend another before I retire tonight.

I am happy to come here tonight to bring the greetings of the State, and also to express to you the gratitude of the people of Rhode Island for the splendid contribution made to the health and well-being of our citizens by the members of this honorable profession. I come, too, to express my personal gratitude to a great number of your members, upon whom I have called from time to time for assistance and guidance, and in consultation, and I am very much elated over the fact that on

every occasion I have found the members of this society very cooperative and willing to assist the people of the state in any capacity that they could.

I take this particular occasion to enumerate one or two, particularly Dr. Ruggles and Dr. Donley, who, only a short time ago, served on a Commission that I designated, to make a study of the conditions at the institutions, and at great personal sacrifice to themselves, they undertook this study, together with Mrs. Gould, formerly of the Congress of Parents and Teachers, and within a short time made a very splendid report to me, a report instrumental in making certain changes that have enhanced the situation considerably.

There has always been a strong bond of cooperation and friendship between this organization and the present state administration. We strive and we sincerely intend to keep it just that way.

*continued on page 452*

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## GOVERNOR JOHN O. PASTORE

*continued from page 448*

Today, government has become quite a complex thing. Most of you realize and appreciate that, and from time to time, there are many problems that loom up that are of mutual concern to your organization and to the state administration. That is not unusual. There is nothing remarkable about that.

I take particular occasion tonight to mention one problem that has been mentioned, and that has come to the attention of the Rhode Island Medical Society, not too long ago, by way of resolution on the part of the House of Delegates. You saw fit to criticize the system of medical examiners in the State of Rhode Island, and suggested at that time that a Committee be appointed by the Rhode Island Bar Association to make a study of the situation and to determine what could be done about it. I am very sympathetic to that study, and I know whereof I speak. Not too long ago, as some of you probably know, I was in charge of the criminal end of the State of Rhode Island, and had a lot to do with reference to prosecution of criminal cases. I have had great contact with the medical examiners in the State of Rhode Island. I say that while our system of medical examiners in Rhode Island is just as out-moded as our present county jail system, the fact still remains that there are, among the medical examiners, and there are at least four that I know in this room tonight, Dr. Ashworth of Providence, Dr. Magill of Providence, Dr. Randall of Foster, Dr. Abbate of Warwick, men who have served with integrity, and these men have served with ability. But, over and above that, we must realize that Rhode Island is a small state in area. In New York City, for instance, they have what I deem to be an up-to-date system of medical examiners. Not too long ago it was my privilege to go to New York in connection with one of the cases that I was prosecuting. I believe it was the Blood case in Pawtucket. At that time, I had a talk with Dr. Gonzales, Dr. Vance and Dr. Halpern who are stationed or located at the Bellevue Hospital in New York City.

They have one focal point, one central point, from which all the medical examinations are made.

True enough, here in Rhode Island, we have a hit-and-miss system that is not the fault of the doctors who serve as medical examiners; it is to be charged up to the system that we have had over a period of years, and no one has seen fit to do anything at all about it. I think it ought to be changed. I think the time has come for a change. We know that there are some localities where it is even hard to appoint, under the requirements of the law, a medical examiner to serve in a particular township. That is only because the doctor who is serving that locality is too busy with his own practice. He hasn't the time. The men whom I have already enumerated to you are very busy practitioners, and they have to drop everything they are doing, when there is any evidence of violence, to review a body. I say that that is not only unfair to the doctors, but it is absolutely unfair to the State as a whole.

I think that some more up-to-date system ought to be worked out. I want the medical association of the State of Rhode Island to realize that insofar as I, at least, am concerned, you shall have all of the cooperation that you desire.

Tonight, in conjunction with your ceremonies, you take occasion to designate and to honor the recipient of the Charles V. Chapin Award. You have chosen Dr. Bayne-Jones. While I have not had the privilege and the honor of meeting him before, I feel that having chosen him, you are selecting a man who is absolutely qualified to receive the award.

Dr. Bayne-Jones, I, as the Governor of the State of Rhode Island, indeed do congratulate you upon this occasion for the members of the association, and for their wives and their friends. I want to assure you that it was pleasant for me to be here.

I have had a good time here tonight, and my only regret is that I must leave now.

Thank you all, very much.

## THE DR. CHARLES V. CHAPIN AWARD

TOASTMASTER FULTON: About six years ago Dr. Gormly suggested that there be a Charles V. Chapin Oration delivered at the Annual Meeting of the Rhode Island Medical Society. That was established by the Society. Subsequently, the City established a Charles V. Chapin Memorial Award, to be given yearly to the man who is selected to deliver the Oration. The sixth annual Oration was given this afternoon by Dr. Stanhope Bayne-Jones of New Haven. Dr. Bayne-Jones is Profes-

sor of Bacteriology at Yale School of Medicine, President of the Army Epidemiological Board, was formerly Brigadier General, Medical Corps, and Director of the United States of America Typhus Commission. He chose as his subject, "The Control of Typhus Fever". Those of you who heard that oration know that it will rank high with those which have gone before.

I am sorry we have to report to you that the Mayor could not be present tonight. When this



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## THE CHARLES V. CHAPIN AWARD

*continued from page 452*

Award was established, it was pointed out that it should be the duty of the Mayor to present the Award. However, he has sent to us, to act for him, the Honorable Frederick S. Barnes, who is a member of the Committee and also Chairman of that

Committee which established this Award. We welcome you, Mr. Barnes, to the 136th Annual Meeting of this Society and I ask you if you will be kind enough to present this Chapin Memorial Award to Dr. Bayne-Jones.

## HON. FREDERICK S. BARNES

## Dr. Charles V. Chapin Memorial Award Committee of the Providence City Council

Dr. Fulton, Chairman, Dr. Bayne-Jones, our honored guest Reverend Dr. Butler of Providence, other distinguished gentlemen on the dias, members of the Rhode Island Medical Society and Providence Medical Association, and friends.

May I extend the apology of Mayor Dennis J. Roberts for his inability to be present on this great occasion. He has asked me to convey to you the greetings of the people of the City of Providence.

I find myself in a rather difficult position because of all the nice things that Governor Pastore has said regarding our honored guest and the members of the medical profession.

However, it is with a great deal of interest that I have noted that the Chapin oration of the day has been given by Dr. Bayne-Jones, and he has addressed you on the "Control of Typhus Fever." There was a day, not so long ago, when such a subject would be out of range of interest for the average American citizen. The World War changed our thinking in such matters, however, as the members of the armed forces, particularly, were immunized against disease as they carried the battle to the remotest jungles of the world, and we are acutely conscious of the great part that medical and public health research has played in guarding our and their lives.

I am sure the veterans of this State have a clearer recognition of the work of Charles V. Chapin, which he carried on for many years in the city of Providence in the face of public criticism and disinterest. His achievements stand forth more clearly to all of us now, and the more fitting it is that the City of Providence should join with the Rhode Island Medical Society and the Providence Medi-

cal Association, on this occasion, to pay tribute to Dr. Chapin's memory.

The extent of Dr. Chapin's influence is a matter of conjecture. His work in our city won the praise of the world.

I am thinking of him in another light, that of an individual whose theories and principles may have had far-reaching effects on his colleagues.

In that connection, I recall to your minds that Dr. Chapin was a fellow student, intern and a close friend of the late General William C. Gorgas, while the two were students at Bellevue Hospital in New York City. It remained for Dr. Gorgas to apply the methods of yellow fever control, when our government built the Panama Canal, for without these sanitary measures, the Canal, which was to be the life-line of our armed forces as we carried on a two-ocean war in this decade, could not have been built.

Therefore, as we pay tribute to the memory of Dr. Chapin, we also pay tribute to all physicians whose war with disease never ceases. We pay tribute, particularly, to the present-day leaders in research, such as Dr. Bayne-Jones, in his former position and his position now as Director of the United States of America Typhus Commission.

On the occasion of this, the 136th Annual Meeting of this historical medical society, in behalf of the City of Providence and the Charles V. Chapin Memorial Award Committee of the Providence City Council, I am happy to award you, Dr. Bayne-Jones, this Chapin Medal, in fitting recognition for the contribution that you, sir, have made to humanity, and the things we expect of you gentlemen of the profession.

## STANHOPE BAYNE-JONES, M.D.

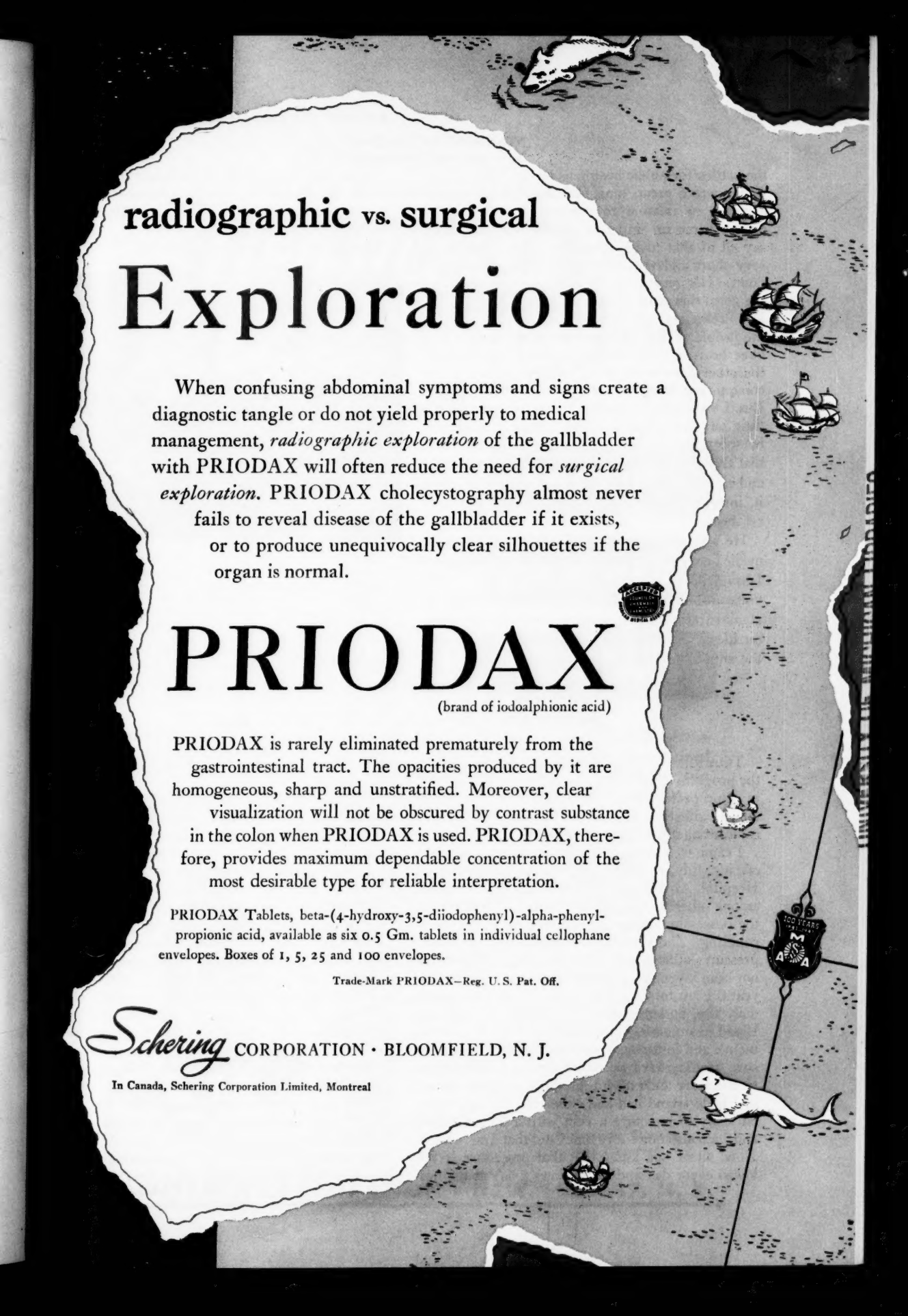
Mr. Barnes, Dr. Fulton, Dr. Pitts, Distinguished guests, Friends. I feel deeply moved by the honor given to me, and, as I said today, the people with whom I have the good fortune to be associated share this with me.

This Award symbolizes or puts in the form of unending treasure and memory a recognition of preventive medicine that seems to me must be deep

in the hearts of all people, physicians and civilians, not only in this room, but in this town, realizing that in the ideas of preventive medicine that Dr. Chapin had, there was, perhaps, the great salvation.

I am a southerner, from Louisiana, who had medical forebears about the time of Dr. Chapin's regime in Rhode Island. My grandfather fought

*continued on page 456*

The background of the advertisement features a dark, textured sea with a large sea monster, resembling a dinosaur, breaching the water. Several sailing ships are shown being attacked or threatened by the creature. A line with a hook and a net is visible on the right side, suggesting a hunt or capture. The overall theme is one of a 'diagnostic tangle' being resolved.

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## STANHOPE BAYNE-JONES, M.D.

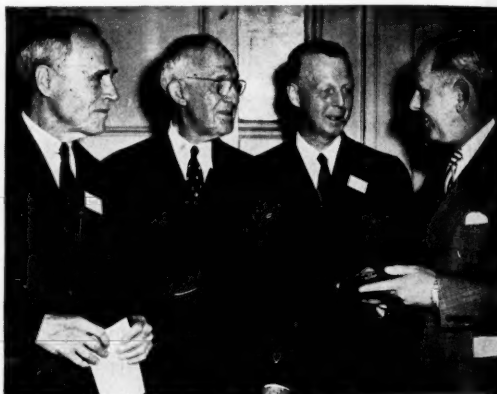
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the battles for public health, as he did. My grandfather wrote great, long books and things about bacteria, in relation to disease. I didn't know until I came up into this region that you could say all of that in the Chapinesque style that was very short and very brief, and very much to the point. His paper, in 1885, about the status of the germ theory of disease at about the time when Dr. Welch and others were getting busy, says to the people of Rhode Island and elsewhere: "You have heard a good deal about what Pasteur and the other Europeans have been doing, but it has come to you from abroad and is hardly believable. But, I want to tell you that I have looked into it a little bit, and germs do cause disease." And then in short and in authoritative language, he tells that there is a transmission of disease by microbes and concludes that they should do something about it, instead of getting rid of bad smells and dirty ash heaps.

He represents a type of the fighting preventive medicine officer of that time, like one or two others I have known, who stood strongly in their convictions and who survived every possible change in administration around them, and who had the highest ideals and who were constantly growing with the situation, learning and leading.

I think that this is the greatest honor that could come to one who has been a follower of Dr. Chapin's and striving to do something akin to the level of his ideals.

I thank you with my deep gratitude.

*Providence Journal Photo*

Councilman Frederic C. Barnes, representing Mayor Dennis J. Roberts, presents the Dr. Charles V. Chapin Award of the City of Providence to Dr. Stanhope Bayne-Jones, of New Haven (second from right), at the 136th Annual Meeting of the Rhode Island Medical Society. Observing the ceremony are Dr. Herman C. Pitts (left), president of the Society, and Dr. Frank T. Fulton, anniversary dinner chairman.

## PRESENTATION OF GAVEL TO H. C. PITTS, M.D.

**TOASTMASTER FULTON:** At this stage in the program I hope I may be pardoned if I indulge in some personalities. These reminiscences, while trivial, will serve to illustrate how marked changes come along almost imperceptibly.

I came to Providence forty-seven years ago this coming July, as Pathologist to the Rhode Island Hospital. At that time there was in the laboratory, among other things, one microscope. There was in the possession of the hospital one outfit for blood counting. The devices for measuring the blood pressure, other than by the tip of the finger, had not been invented, nor were they in use for several years. I am told there are now 26 microscopes in daily use, and that many individuals using them. Blood examinations amounted to 3740 in a recent month and in a recent year to 38,600. Blood pressure readings are taken almost as commonly as temperature and pulse. I am quite sure that no one in Rhode Island had had either the courage or the curiosity to puncture a vein with a hollow needle and I am also quite sure that I did that first, myself. Now, all of you know that that procedure is followed every day and many times a day at the hos-

pital, either to withdraw blood for diagnosis or to give treatment.

About a year after I came, Dr. Pitts came to the hospital as an Intern. There were 8 Interns who lived in what was called, "Intern Alley", and I lived with them. We were all good friends and most of us were good workers. I might say by way of parenthesis that there are now 20 Interns and upward of 20 Residents. Dr. Pitts spent quite a little time as a voluntary worker in the Pathological Laboratory. I soon recognized him to be industrious, intelligent, aggressive, progressive and venturesome—characteristics which he still retains, and we became intimate friends. I did note this last year signs of timidity when I had trouble in persuading him to fly across the Gulf of Mexico with me. When his internship had terminated, we, together, left the hospital for other living quarters and settled at the corner of Angell and Thayer Streets in a 100-year-old house which had been moved from somewhere else to that place. There we had offices, diagonally across from Anthony's Drug Store. Our arrival caused one man to make a remark which was later repeated to me: "There are

*continued on page 458*



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## PRESENTATION TO HERMAN C. PITTS, M.D.

*continued from page 456*

two more doctors who have come up here to starve". Who those fellows were that starved, we never did find out. But there was one doctor, still living, which gave us comfort. At that time most of the doctors of consequence were on either Benefit or Broad Streets. My Secretary noted in the telephone book the other day that there are now 182 doctors on Angell and Thayer and Waterman Streets. Dr. Pitts did not starve. Instead of starving during these long intervening years, he has done much to his own credit, to that of the City, the State, to our profession and for the benefit of the community. As President he has given outstanding leadership during the past year. He has served for two years as President of the American Society for the control of Cancer, is now President of the Rhode Island Society for the Control of Cancer. He is a member

of the American Society for Cancer Research, a Diplomat of the American Board of Surgeons, a member of the College of Surgeons, and in World War I he was Major and Chief of Surgical Service at Base Hospital 77 in France, and last but not least, he received the Temple Emanu-El Men's Club Award for "outstanding achievement in the field of civic improvement, human betterment and the advancement of American ideals", in 1942.

Dr. Pitts, it gives me great pleasure to be the person who is to present to you this gavel as a souvenir of your Presidency. It is a gift from the members of the Rhode Island Medical Society. It will probably be of little use, as it is an emblem of past authority and not future, but I hope it will be an heirloom which your family may cherish.

## HERMAN C. PITTS, M.D.

## President, Rhode Island Medical Society

Thank you, Doctor Fulton. I can assure you that I will cherish this gavel for the rest of my life. My young son is in the Harvard Medical School now, and I trust, will carry on the family tradition of medicine, so that this will always be a prized possession of the Pitts family.

Mr. Anniversary Chairman, Dr. Bayne-Jones, Mr. Barnes, and all these other distinguished gentlemen at this head table. After such a very flowery introduction, I hesitate to get up here and face you all. It requires more courage than I displayed in flying from New Orleans to Guatemala!

The Governor spoke, when he came in, of the remarkable fact that we were able to get so many doctors together in one room. He didn't mention the doctors' wives at all. But as I look around, I can see quite a number of the doctors' wives here present. And this marvelous gathering of you wives gives me a great opportunity to say a few words to you. Your husbands are going to be inflicted with a few remarks from me tomorrow, so that it is quite fitting that you share-and-share-alike with them.

I suppose this evening marks one or two important things in my life. In the first place, it is a sort of swan-song of my presidency of the Rhode Island Medical Society. Tomorrow, the mantle of authority descends to abler shoulders in the person of my very good friend, Dr. Ruggles. It marks, also, the end of a very pleasant year, which has passed very quickly, yes, much more quickly than I dreamed it would when I was elevated to this honor.

The year has been pleasant because of a number of things. The two most important are, first, the fact that I have had the best sort of cooperation from every member of the Society. I see a great many men here present who have taken part, yes, a very enthusiastic part, in running the Society during the past year. It would be impossible to single out these various gentlemen, as I see them before me, but my warmest thanks to them just the same. But, I should like to single out one in particular. Until he was taken ill, he was extremely faithful in making the long trip from Westerly to all of our meetings, and it gives me a great deal of pleasure to introduce a man who doesn't need much introduction truly enough. I refer to our Vice President, Dr. Scanlon. I appreciate your help, Doctor, in getting through a good many of those long and difficult meetings.

The year has been pleasant for another very cogent reason. I refer to the very efficient way in which our Executive Secretary, John Farrell, has taken work off my shoulders. As a matter of fact, I don't see how any President of the Rhode Island Medical Society ever ended a year in good health before Mr. Farrell came to us!

I hope that the cause of medicine has been advanced a little bit during the past year. I can assure you that we have had much discussion, and any one who has attended any of the meetings of the House of Delegates, I am sure, will agree with that. Every year medicine requires more and more from each man in practice, and in consequence,

more and more from each of you wives who has been unfortunate enough, or perhaps fortunate enough, to have married one of us. It is about these added requirements I wish to speak.

As you walked in this evening, I failed to notice any lagging steps, any backward glances as if you weren't quite sure you belonged here. You do belong now in this day and generation, but I can assure you if one of our founder members of 136 years ago could come back tonight, the thing that would astonish him most would be seeing women in a gathering of professional men to do honor to an internationally known scientist come among us to honor another great scientist — our own beloved Dr. Charles V. Chapin.

But perhaps you do not realize that this is a woman's world! It hasn't been such for so many years. Even I can remember when women were kept in a condition of servitude by bustles and heavy skirts that trailed the ground. My memory, fortunately, doesn't go back to hoop skirts!

The change came somewhere in the nineties. It was gradual and not entirely unobserved, for Tom Masson could lament that "Woman has usurped all the prerogatives of man save bi-furcated garments and a sense of humor and these she approximates by diaphonous skirts and a superficiality". Alas, or perhaps not alas, if old Thomas were alive today he would find woman in many positions where a sense of humor is of paramount importance and could probably notice that diaphonous skirts are no longer necessary to reveal their charms!

And by all this emancipation of woman, man has profited. There is never a movement of any importance that is not participated in by women. I speak feelingly when I pay tribute to the excellent work the women of the Field Army have done in spreading cancer education, raising money for the cancer work, and in bringing hope and comfort to the many cancer sufferers.

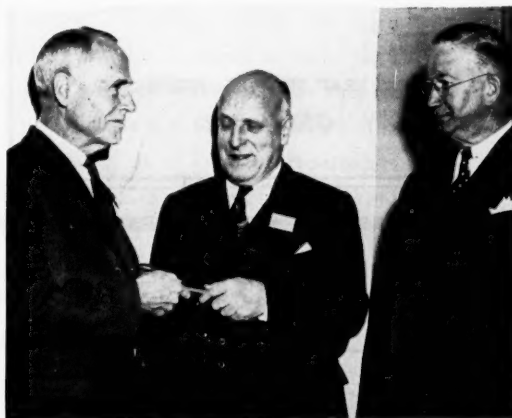
Medicine, I believe, is at the parting of the ways. One road leads to greater glory in service to mankind through individual effort, through the natural desire of man to excel his neighbor in knowledge and skill. The other road leads to the dead level of mediocrity through control of medical practice by the State. There would be no stir of ambition to excel in the breast of the medical man serving the State for he would know very well that the reward of the dullard would be as great as the reward of the brightest and most conscientious. And the recipient, the worker who has his weekly pay envelope docked to pay for this semi-charity, is the loser in receiving more medicine, perhaps, but just the kind of medicine one would expect from mediocrity — poor medicine. Perhaps worse than

that, too, he would lose the desire, the ambition to provide for the hazards of life himself and the "ultimate result of shielding men from the effects of folly is to fill the world with fools".

From every consideration medicine must not be allowed to take this road, and you women can do a tremendous lot to keep it on the right track. Our new association of the wives of doctors in the Auxiliary is the organization through which help can be given. You are strong both collectively and individually. Collectively as a body you can influence legislation. Individually in your women's clubs, at the bridge table, in your churches, in social gatherings, you can have a tremendous effect in moulding public opinion, and "public opinion is stronger than the Legislature, and nearly as strong as the Ten Commandments". Make yourselves familiar with the ideas of some of these well-meaning but misguided people who would turn the clock of medical advance back 50 years. Be our publicity agents. Help us keep medicine going forward continuously on the path of greater service to mankind.

## PATRONIZE

## JOURNAL ADVERTISERS



*Providence Journal Photo*

Dr. Arthur H. Ruggles (center) receives the gavel as new President of the Rhode Island Medical Society from retiring president, Dr. Herman C. Pitts, as Dr. Joseph C. O'Connell, president-elect observes the ceremony.

## WOMAN'S AUXILIARY

*concluded from page 441*

and Mrs. James McKendry seconded the motion. The motion was carried.

The following candidates were nominated: Mrs. James O'Brien, Mrs. Martin Grimes, Mrs. Joseph Kent and Mrs. Louis Cerrito.

A motion to close the nominations was made by Mrs. Thomas Nestor and seconded by Mrs. Gustaf Sweet. Carried.

The results of the tellers showed that the following members were elected. From the Board of Directors, Mrs. Stanley Davies received 41 votes and Mrs. Thomas Dolan, 38 votes. From the floor Mrs. Paul Cook received 59 votes, Mrs. Martin Grimes 47, Mrs. Francis Hanley 46, Mrs. George Waterman 44, Mrs. Elihu Wing 38.

Mrs. Roland Hammond, chairman of the Luncheon Committee, was given a rising vote of thanks for her efforts in achieving such an enjoyable luncheon for our first annual meeting.

The meeting adjourned at 4:30 p. m.

Respectfully submitted,

MARY A. FARRELL,  
*Secretary*

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1. Surg., Gynec. and Obst.  
74:390 (Feb. 16) 1942.

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## HOSPITAL ASSOCIATION OF RHODE ISLAND

### PROVIDENCE LYING-IN HOSPITAL

The birth rate not only remains high but shows a considerable increase over the corresponding period in 1946. 2694 confinements during the first four months of 1947 as against 1790 during the first four months last year. We have every reason to believe that the latter half of this year will show no appreciable increase over the same period in 1946. The shortage of nurses remains a problem. There may be no real decrease in the number of nurses but the demands on hospitals to care for such an increased load does result in hospitals having too few nurses, for the patients they are caring for.

The past few years have shown an out of proportion increase in the number of premature infants. This has necessitated drawing plans for a much larger premature department and work should be completed here in another month. This addition will allow for the care of 26 babies in incubators in one unit and a somewhat larger unit for their care after they are able to leave the incubators. A third unit has been provided for the nurses office and a wash room and gown room for the visiting pediatricians. A glassed-in corridor provides for visitors viewing the infants, without coming in contact with them.

Luncheon was served to members of the New England Obstetrical and Gynecological Society on April 30, 1947. About 225 members and guests attended the afternoon meeting held at the Lying-In Hospital. The following papers were presented.

1. Symposium on Rh factor
  - (a) William E. Furniss, M.D. Laboratory and Theoretical Aspects
  - (b) John G. Walsh, M.D. Clinical Aspects
  - (c) Maurice Adelman, M.D. The Pediatric Aspect
2. Congenital Anomalies of the Female Genital Apparatus, Walter S. Jones, M.D.
3. Treatment of Placenta Previa and Separated Placenta, John F. Murphy, M.D.
4. Trends in the Indications for Cesarean Section, Alfred L. Potter, M.D.

### THIRD N. E. HOSPITAL ADMINISTRATORS INSTITUTE

The Third New England Institute is to be conducted by the American College of Hospital Administrators in cooperation with Brown University and in affiliation with the New England Hospital Assembly and the Hospital Associations in the States of Connecticut, Maine, Massachusetts, New

Hampshire, Rhode Island and Vermont. This Institute will be open to administrators and assistant administrators with registrants limited to 100.

#### Honorary Chairman

Henry Merritt Wriston, Ph.D., Litt.D., LL.D.  
President, Brown University

#### Officers

##### Director:

Oliver G. Pratt, Executive Director, Rhode Island Hospital; President Hospital Association of Rhode Island

##### Associate Director:

Albert G. Engelbach, M.D., Director, Cambridge Hospital

##### Secretary:

Paul J. Spencer, Director, Lowell General Hospital; Secretary, New England Hospital Assembly

##### Treasurer:

Lester E. Richwagen, Director, Mary Fletcher Hospital; Treasurer, New England Hospital Assembly

#### Executive Committee

##### Officers of the Institute

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Charles Anthony McDonald, Ph.B., M.D.  
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Director of University Health Services  
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James Walter Wilson, Ph.D.  
Day Professor of Biology

##### Hospital Administrators:

Nathaniel W. Faxon, M.D.  
Rev. Donald A. McGowan  
Donald S. Smith  
Charles F. Wilinsky, M.D.  
Frank E. Wing  
Wilmar M. Allen, M.D.

#### Advisory Committee

Maine: Stephen S. Brown, M.D.  
Miss Pearl R. Fisher, R.N.  
Frederick T. Hill, M.D.

Massachusetts: Sister Angelica  
Miss Abbie E. Dunks  
Gerald F. Houser, M.D.  
Eugene Walker, M.D.  
Richard O. West  
Scott Whitcher  
Leverett S. Woodworth, M.D.

Connecticut: Richard J. Hancock  
Albert W. Snoke, M.D.

Vermont: Laurence C. Campbell

New Hampshire: Miss Anne C. MacDougall, R.N.  
N. Conant Faxon

Rhode Island: Miss Helen M. Blaisdell, R.N.  
Francis C. Houghton  
Harmon P. B. Jordan, M.D.  
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## MEETING OF HOUSE OF DELEGATES

*Rhode Island Medical Society*

May 7, 1947

A REGULAR meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 7, 1947. The meeting was called to order by President Herman C. Pitts at 8:10 p. m.

The following members were in attendance:

Rocco Abbate	Albert H. Jackvony
Charles J. Ashworth	Walter S. Jones
Robert Baldrige	Francis King
Philip Batchelder	Louis I. Kramer
Alex M. Burgess	Herman A. Lawson
Peter Pineo Chase	Earl J. Mara
B. Earl Clarke	Edward A. McLaughlin
William P. Davis	John C. Myrick
Donald L. DeNyse	Michael J. O'Connor
H. Lorenzo Emidy	Herman C. Pitts
Charles L. Farrell	Arthur H. Ruggles
David Freedman	Julianna R. Tatum
Henry Hanley	Daniel V. Troppoli
Russell R. Hunt	Frederick A. Webster
G. Edward Crane	Edwin B. O'Reilly
Robert Henry	Guy W. Wells
	U. E. Zambarano

Also present were Mr. John E. Farrell, executive secretary, and Mr. Charles Williamson, legal counsel.

In the absence of Dr. Morgan Cutts, secretary, his annual report was read by the Executive Secretary. It was moved and seconded that the report be accepted and filed [See page 470 for Report.]

**Report of the Committee on Industrial Health:**

In the absence of Dr. Stanley Sprague, chairman of the Committee on Industrial Health, his report with recommendations was submitted by Dr. Charles L. Farrell, member of the Committee. This report contained this specific recommendation:

That the House of Delegates authorize the Committee on Industrial Health to draft a suggested fee schedule for workmen's compensation benefits, and that such schedule be submitted to the Society for approval before being made public.

Dr. Farrell elaborated on the problem relative to the Workmen's Compensation Act.

After a brief discussion, it was moved that the report of the Committee on Industrial Health be accepted and that the recommendation contained

therein be approved. The motion was seconded and adopted.

**Report of the Committee on Public Laws:**

The Executive Secretary read the report of the Committee on Public Laws for Dr. William H. Foley, chairman of the committee, who was absent. The report included two recommendations:

1. That the House go on record as opposing the passage of the Health Act now before the Assembly in its entirety, and that it recommend the passage of sections of the Act separately in order that closer scrutiny could be given each section by the Assembly.
2. That the House go on record as expressing its desire to be considered in the determination of representation on special consideration to be given the Workmen's Compensation Laws, and that it request the Governor to name a member of the Society to this commission in view of the fact that medical care constitutes the major determination for compensation under these laws.

Dr. Baldrige moved that the report of the Committee be accepted and the recommendations be adopted. The motion was seconded and passed.

**Treasurer's Report:**

Dr. Charles J. Ashworth, treasurer, submitted his annual report for the year 1946.

Dr. Albert H. Jackvony moved that the annual report of the Treasurer be accepted and placed on file. The motion was seconded and adopted.

**Relations with the Veterans Administration:**

Dr. Herman A. Lawson, chairman of the Committee on Relations with the U. S. Veterans Administration, reported on the difficulties his Committee had encountered at its conference with the Veterans Administration. He stated that the fee schedule, carefully drafted by the Committee and subsequently approved by the House of Delegates, had been rejected by the Veterans Administration and that his Committee was not desirous of amending the schedule to meet a fee table drafted in Washington.

He stated that the "home town service" for med-



ical care for veterans has not been borne out by the facts in Rhode Island, and that it exists only in emergency cases here. He expressed opposition to the publicity to such service.

Commenting on the fee schedule, he called attention to the action of the House, and reported that the Committee was considerate of all factors in drafting the schedule for the Veterans Administration. He pointed to the fallacy of a uniform fee schedule for the entire country without respect for the variance due to the operating overhead for the physician resident in an urban as compared with a rural area.

He reported that Rhode Island was not alone in this conflict with the VA, for the State of Ohio had had much discussion and comment when the program was established there, and Erie County, New York Medical Society, is presently engaged in a controversy due to the fact that the VA is requesting that their fee schedule be amended to match the one drafted by the national office of the Veterans Administration.

He concluded his summary report by stating that he personally felt that the House of Delegates should oppose the dictation of fees from Washington.

#### Discussion:

An inquiry was made as to how the fee schedule

was drafted, and Dr. Lawson reported that it was patterned after the one drawn in several other states plus consideration of the charges prevailing in Rhode Island. He stated that the important thing was not what the difference in fees might be, but who is to set a fair fee, the society or the Veterans Administration.

Dr. C. L. Farrell stated that since the VA had asked the Society to submit a schedule of fees, and it had done so, that no change should be made. Therefore, he moved that the House of Delegates support the Committee on Relations with the Veterans Administration on the stand that it has taken, and further that the House go on record as requesting the adoption of the fee schedule already approved by it for medical services to veterans. The motion was seconded.

In the discussion of the motion Dr. A. M. Burgess pointed out that the present situation was a decided change from the representations made by General Hawley when he addressed the Society a year ago.

The motion was put to a vote and it was unanimously adopted.

Dr. H. C. Pitts suggested that the Committee on Veterans Affairs might consider a meeting with officers of the American Legion and the Veterans of Foreign Wars to acquaint them with the posi-

*continued on next page*

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## HOUSE OF DELEGATES

*concluded from preceding page*

tion of the Medical Society in this particular problem of medical care for veterans. Dr. Lawson agreed that such a step would be a good one to take if the Veterans Administration does not agree with the policy of the Society. He also suggested that the Society communicate with other medical groups to determine their experience in this matter.

*Communication from the Blue Cross:*

Dr. Arthur H. Ruggles read a communication to the House addressed to Dr. Herman C. Pitts from the Hospital Service Corporation of Rhode Island suggesting a possible solution to the proposed surgical plan and asking that the communication be brought to the attention of the proper authorities and be given consideration. Dr. Ashworth moved that the communication be laid on the table until the House heard the report of the Surgical Committee. The motion was seconded and adopted.

*Surgical Insurance Study Committee:*

Dr. Rocco Abbate read a progress report from the Surgical Insurance Study Committee, copy of which was distributed to each member of the House of Delegates. [See page 472.]

There was a brief discussion of the report with

members of the Committee answering various inquiries directed by members of the House. The discussion was concluded with a motion by Dr. Walter S. Jones that the House instruct the Committee on Surgical Insurance Study to explore the question further and to report to the House of Delegates at its convenience, and he further moved that the House table the communication from the Blue Cross without answer as to the proposition contained therein. Dr. Mara seconded the motion.

Dr. H. Lorenzo Emidy moved to amend the motion to provide that the communication from the Blue Cross be turned over to the Surgical Study Committee. Dr. Ashworth seconded the amendment. After a brief discussion the amendment to the motion was adopted and the entire motion was adopted as amended.

Dr. Pitts discussed the question of a press release relative to the Surgical Study Committee's report. There was lengthy discussion of this matter by members of the House, the executive secretary and the legal counsel. At the conclusion of the discussion, Dr. Ashworth moved

"that the press be informed that the Committee on the Surgical Insurance Study had made a progress report which had been received and accepted by the House of Delegates, and that the House had instructed the Committee to continue and explore all possible plans for prepaid surgical insurance by private companies as well as the Blue Cross."

*continued on page 469*

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## HOUSE OF DELEGATES

continued from page 466

The motion was seconded and adopted.

**Recommendations from the Council:**

1. *Blue Cross Directors:* In the absence of the secretary, the executive secretary reported a recommendation to the House.

He reported that a recommendation of the Council made in January had not been brought to the House of Delegates' meeting in that month. The recommendation was as follows:

"that the House of Delegates at the proper time re-elect the present members of the Society representing it on the Board of Directors of the Hospital Service Corporation."

Dr. Charles L. Farrell moved to lay the recommendation on the table. The motion was seconded.

There was discussion on the motion by members of the House and Dr. R. R. Hunt summarized it by pointing out that the House must decide whether it wants the men to serve officially or not. Dr. Pitts called for a vote on the motion. The motion was defeated.

Dr. Troppoli moved that the House of Delegates re-elect the seven physicians previously named to serve as directors of the Hospital Service Corporation, and that these representatives continue for the remainder of the current year. The motion was seconded and adopted.

2. The executive secretary presented the following recommendation from the Council:

**Council:**

"That the Committee on Publication be omitted as a Standing Committee of the Society, and that an Editorial Board shall be appointed by the Editor-in-chief with the advice and consent of the President of the Society, and that the President, the President-Elect, and the Secretary shall be ex-officio members of the Editorial Board.

The motion was made that the recommendation be adopted. The motion was seconded.

**Discussion:**

Dr. Ashworth discussed the recommendation and urged the deletion of the provision that the Editorial Board shall be appointed by the Editor "with the advice and consent of the President" on the grounds that such action would hinder the Editor in the discharge of his duties and would not work to the advantage of the Journal. Dr. Farrell stated that if the Society is to have a Journal of value it must have an editor in whom it has full confidence and must give him the privilege of picking his staff of assistants. Dr. Chase discussed the problem and cited the fact that the House now controls the Journal and the Editor, and he expressed the opinion that the authority should remain there or else delegated directly to the Editorial Board or the Publications Committee. He stated that the Editor-in-Chief must have some leeway in assigning his staff, and he pointed out that

the Editor and the staff are entirely subservient to the Society.

There was further discussion which was closed with Dr. C. L. Farrell's statement that the recommendation would involve many changes including an amendment to the By-Laws of the Society, and therefore the House should, in his opinion, defeat the motion. Dr. Pitts called for a vote and the motion was unanimously defeated.

3. *Recommendation on Medical Examiners:* The executive secretary submitted the following recommendation from the Council:

"That the House appoint a committee, and that it request the Rhode Island Bar Association to appoint a committee, and that these committees meet jointly to study and investigate the medical examiner system in Rhode Island, and that they report back to their respective societies with recommendations."

It was moved, seconded and adopted that the recommendation be accepted.

Dr. Pitts called for nominations for the committee to represent the Rhode Island Medical Society. Dr. C. L. Farrell nominated Dr. William H. Foley; Dr. DeNyse nominated Dr. B. Earl Clarke; Dr. Ruggles nominated Dr. Edward A. McLaughlin. It was moved that the nominations be closed. The motion was seconded and adopted.

It was moved that the three men nominated be elected. The motion was seconded and adopted.

continued on next page



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Dr. B. E. Clarke was delegated chairman of the committee by the President of the Society.

**Nominations for Officers and Elected Committees:**

Dr. Pitts stated that each member of the House had received a copy of the nominations of the Council for the officers and standing committees of the Society to serve for 1947-1948.

Dr. C. L. Farrell stated that Dr. Sprague, chairman of the Committee on Industrial Health, requested that Dr. Francis Hanley be nominated for the Committee on Industrial Health. After brief discussion Dr. Farrell withdrew his nomination.

It was moved that the standing committees as nominated by the Council be declared elected. The motion was seconded and adopted.

Dr. Louis I. Kramer moved that the slate of officers as submitted by the Council be accepted. The motion was seconded and adopted.

In accordance with a suggestion by the legal counsel, Dr. P. Batchelder moved that the House name Dr. Francis Hanley as an alternate member of the Committee on Industrial Health. The motion was seconded and adopted.

Dr. Earl Mara moved to place in nomination the following committee to serve as the Committee on Publications:

John E. Donley, M.D., *Chairman*  
Harold G. Calder, M.D.,

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## RHODE ISLAND MEDICAL JOURNAL

C. S. Dotterer, M.D., of Newport  
Peter Erinakes, M.D., West Warwick  
Charles J. Ashworth, M.D.  
Henry E. Utter, M.D.  
H. Lorenzo Emidy, M.D., Woonsocket  
Charles L. Farrell, M.D., Pawtucket  
John E. Ruisi, M.D., Westerly

Dr. F. King moved the election of this committee as named. The motion was seconded and adopted.

**Resolution Regarding Dr. Peter Pineo Chase:**

Dr. B. Earl Clarke submitted a resolution drafted by Dr. Roland Hammond as follows:

"WHEREAS, The articles entitled "Your Health" written by Dr. Peter Pineo Chase and published in the local newspapers, have received well-deserved praise from the medical profession and the laity alike,

"WHEREAS, These essays, together with the question and answer columns, have been composed in easily comprehended language, often compared with conditions well understood by the reader and characterized by a dry humor which has made them both interesting and readable,

"WHEREAS, This column is of great value in assisting the educational work of the Rhode Island Medical Society in making disease and its treatment more easily understood by the layman,

"THEREFORE, BE IT RESOLVED, That the Rhode Island Medical Society express its approval of these articles and its hope that Dr. Chase will continue the educational program so auspiciously begun."

Dr. Batchelder moved that the House adopt this resolution. The motion was seconded and unanimously adopted as the House applauded the action.

**Miscellaneous Business:**

Dr. Pitts reported that no delegate had been assigned to attend the annual meeting of the New Hampshire State Medical Society, and he inquired if any member of the House desired to accept this assignment. There was no acceptance.

**The Taft Bill:**

Mr. Willamson spoke briefly regarding the Taft Bill now before Congress, and he cited the implications of the Act and the position that organized medicine would probably have to take. Mr. Farrell read a very recent communication from Washington relative to the hearings to start on this legislation May 21.

**Group Health and Accident Insurance:**

Dr. David Freedman inquired whether the Society had given any consideration to group health and accident insurance for the members of the Society. The executive secretary reported that the Council had authorized the appointment of a committee by the President to make the study. Dr. Mara reported that a plan had been adopted by the Pawtucket Medical Association with the Commercial Casualty Company and that at the present time one-half of the members had joined up.

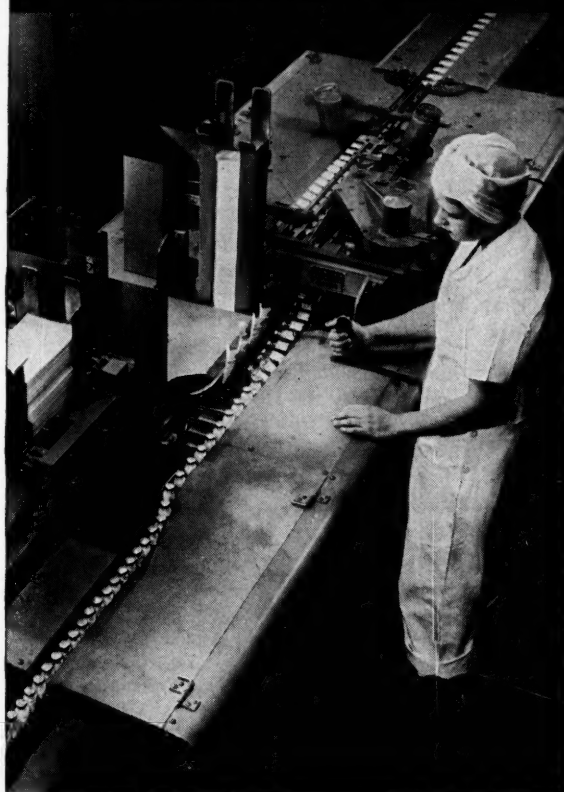
The meeting adjourned at 11:10 p. m.

Respectfully submitted:

MORGAN CUTTS, M.D.  
*Secretary*



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### SURGICAL STUDY COMMITTEE REPORT

At the January meeting of the House of Delegates it was voted that a committee of five members be appointed by the House to study ways and means of putting into effect a Rhode Island Medical Society low-cost prepaid surgical plan as of its own, or through the possibility of having a private insurance company take the plan over.

Recognizing the necessity for activating this new committee as soon as possible, the President of the Society called a special meeting of members of the House present at the mid-winter meeting of the Society on February 3. At that meeting it was agreed that the President should appoint a committee subject to the approval of the House, and that notice should be sent to each Delegate notifying him of the action taken, and allowing him to offer counter nominations. This procedure was pursued, and the committee was officially named in mid-February to consist of the following members:

Drs. Rocco Abbate of Lakewood, chairman, Arcadie Giura of Warren, Charles L. Farrell of Pawtucket, Charles J. Ashworth of Providence, and J. Murray Beardsley of Providence.

At its first meeting the Committee determined that it should first explore group insurance programs now in operation before turning to the consideration of establishing a plan under the complete jurisdiction and administration of the Society. Members of the Committee, together with the President of the Society, attended a conference held in Hartford by the Connecticut State Medical Society at which outstanding insurance executives discussed their participation in prepaid voluntary surgical plans with medical society cooperation.

Subsequently the Committee held a meeting at which the president of the Association of Health and Accident Insurance Companies in Rhode Island outlined the extent to which private insurance could participate in a program such as proposed by the Society.

Although the existence of this new committee of the Society was widely publicized, there has been no request to it from the Blue Cross of Rhode Island for further consideration. Therefore, the Committee can only conclude that the Blue Cross has not altered the stand it took in making its final proposition to the House of Delegates in January.

Meanwhile, studies were carried forward by the Committee of the plans adopted in Wisconsin and in South Dakota where the state medical associations have utilized private insurance to provide low-cost surgical coverage. Complete data on these plans is on file at the executive office, and therefore is not included in this preliminary report to the House of Delegates.

Our next step was to present our Rhode Island proposal to all the group health and accident insurance companies licensed to operate in this state. In a covering letter we carefully noted that we are not requiring one plan, but are seeking a solution to our problem of extending the distribution of low-cost prepaid surgical insurance to the people of Rhode Island, and we are prepared to consider any worthwhile proposal from any one company, or group of companies. The proposal that we submitted included the indemnity schedule previously approved by the House of Delegates, although we realized that this schedule includes the listing of many items that might better be decided by a conference committee once a plan is adopted.

Our proposal to these companies included, in addition to the indemnity schedule of benefits previously approved by the House, policy provisions that we felt should be incorporated in any contract, and also the following general comments:

"Any insurance company licensed to do business in Rhode Island is invited to submit a plan to provide for payments according to the attached indemnity schedule, or with possible amendments to this schedule, and each company would be expected to include the following provisions:

- "1. When the indemnity schedule is finally adopted the contracts must be written without alteration in any respect without approval of the Rhode Island Medical Society.
- "2. As a condition for the purchase of the policy there must not be attached any other type of insurance. This does not preclude the inclusion of other phases of health and accident coverage, but does require that only the surgical coverage shall be available to the purchaser without the necessary purchases of other coverage.
- "3. An Advisory Committee composed of an equal number of representatives of the Rhode Island Medical Society and of insurance companies underwriting any plan adopted shall consider and resolve all problems arising in the administration of the plan.
- "4. Each company agreeing to write the plan adopted shall agree to present a semi-annual report and analysis of its financial and enrollment experiences under the plan to a committee appointed by the Rhode Island Medical Society.

*continued on page 475*

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## SURGICAL STUDY COMMITTEE REPORT

*continued from page 472*

"5. Each company shall use only such advertising material, report, assignment and other standard forms as approved by the Advisory Committee.

"6. Each company shall properly promote the adopted plan and shall conscientiously endeavor to secure wide coverage among the population of this State."

The re-action to our communication has been excellent. We have received preliminary reports from several companies, and others have asked for further time to study the proposal. Most significant is the fact that the matter is now under advisement by the National Conference Committee on Health Insurance which was organized last year for the purpose of conferring with representatives of the medical profession and hospitals in the development of insurance plans in the health insurance field.

This national committee is composed of representatives of seven trade associations and thus includes representation from substantially all companies writing accident and health insurance in the United States. The Associations are the American Mutual Alliance, the National Fraternal Congress of America, the Bureau of Personal Health and Accident Underwriters Conference, the American Life Convention, the Life Insurance Association

of America, and the Association of Casualty and Surety Executives.

Our Committee has planned a meeting for later this month with a sub-committee of this national group to explore our proposal. We hope that this meeting will provide us with sufficient factual information to allow us to make definite recommendations to this House within the next two months.

This report is made to the House at this time mainly that the Delegates may be informed that the Committee has made definite progress in its assignment. The Committee will welcome advice and suggestions from any member of the Society, and it asks the continued support of the House of Delegates in the completion of its study.

Respectfully submitted,

COMMITTEE ON THE STUDY OF PREPAID  
SURGICAL INSURANCE

Rocco Abbate, M.D.  
Charles L. Farrell, M.D.  
Charles J. Ashworth, M.D.  
J. Murray Beardsley, M.D.  
Arcadie Giura, M.D.

May 7, 1947

## Ship ahoy!...Have a Coke



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## DISTRICT SOCIETY MEETINGS

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### WOONSOCKET DISTRICT MEDICAL SOCIETY

The April meeting of the Woonsocket District Medical Society was held on April 15, 1947, at the St. James Hotel in Woonsocket. The meeting was called to order by Dr. Joseph Reilly, President, at 9:30 p. m.

A motion picture film on "Intragastric Drip Therapy of Peptic Ulcer" was shown by representatives of the Wyeth Company. The photography of the interior of a dog's stomach, illustrating experimental ulcer formation, proved to be extremely interesting.

Dr. Reilly presented a letter which he had received from the Rhode Island insurance adjusters suggesting the Society be represented in a discussion of the question of insurance fees for herniorrhaphies. Motion was made by Dr. Joseph McKenna that a committee of three be appointed by the President to comply with this request. The motion was seconded by Dr. Euclide Tremblay and passed by the Society.

The application of Dr. Carlo DeStefani was presented and he was elected to the Society.

The meeting adjourned at 10:55 p. m., and a collation was served. The attendance was twenty-four.

Respectfully submitted,

ALFRED E. KING, M.D.

*Secretary*

### KENT COUNTY MEDICAL SOCIETY

The May 6, 1947, meeting of the Kent County Medical Society was held at the office of the President, Dr. Peter C. Erinakes. There were thirteen members present at the meeting.

The Wyeth Company showed an interesting and practical film on "Post Partum Hemorrhage."

The meeting proper was called to order at 10:00 p. m. The President, Dr. Erinakes, read the minutes of the last meeting, which were accepted after a motion made by Dr. Abbate and seconded by Dr. Mack.

The usual committee of Drs. Taggart, Hudson and Farrell was appointed to make arrangements for the June meeting, which consists of the annual clambake.

Dr. Lamb's name was suggested and accepted to

act as Secretary in the absence of the Secretary, Dr. Joseph Harrop. The Secretary was requested, on suggestion of Dr. Taggart, to send a copy of the By-Laws of the Society, with all amendments, to the Rhode Island Medical Society.

The assembly then discussed "Business Affairs," as called for in the Constitution and By-Laws of the Society, Chapter II, Section 3.

These included the discussion of ads or contributions to the different programs and societies, charitable or otherwise.

Dr. Abbate suggested that if the members of the Society contribute to a program, they should make an effort to keep their names anonymous, as required by the ethics of the profession.

The President directed the Secretary to send notices to each member, concerning these contributions, requesting them to keep their names anonymous, if and when they wish to make contributions.

Dr. Mack then suggested that each member contribute towards paying for the luncheon and refreshments so graciously offered the members by the President at the monthly meetings.

M.D. emblems for the cars were then discussed, and it was moved that the matter be taken up with the State Society at an opportune date in the future in order to approach the Registry of Motor Vehicles, and talk over the feasibility of having M.D. added on Doctors' license plates to distinguish the M.D.'s from all the other "Doctors'" shields, which try to imitate the approved A. M. A. emblem.

Dr. Abbate gave a report on the latest steps done to offset Socialized Medicine, and the up-to-date story of the conflict with the Blue Cross, in regard to the "Rhode Island Medical-Surgical Plan."

The meeting adjourned at 11:00 p. m.

Respectfully submitted,

FRANCIS D. LAMB, M.D.

*Secretary, Pro-tem*

### WASHINGTON COUNTY MEDICAL SOCIETY

A regular meeting of the Washington County Medical Society was held at the Westerly Hospital April 9, at 11:30 a. m.

The Secretary reported that no essay had been received in the contest sponsored by the American Association of Physicians and Surgeons.

*continued on page 478*



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## WASHINGTON COUNTY SOCIETY

*continued from page 476*

Dr. Tatum presented the proposal of the Rhode Island Medical Society for a state-wide health federation of the public and voluntary non-profit organizations in the State. The Secretary was appointed representative of this society.

Dr. Freeman B. Agnelli gave a very interesting talk on "Streptomycin in the Treatment of Tuberculosis." As a patient in the Fitzsimmons General Hospital of Denver, Colorado, he had a chance to study some of the cases in Project X. His remarks were not for publication for the Army has not yet released a report on the project, but his personal conclusions are that at the present stage of development Streptomycin should be used only when all other therapy has failed.

There was some discussion following, and the meeting adjourned to dine at the Haversham Inn.

Respectfully submitted,

JULIANNA R. TATUM, M.D.

Secretary

## PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, May 5, 1947. The meeting was called to order by President Guy W. Wells at 8:35 p. m.

The minutes of the previous meeting were read by Dr. Troppoli.

The secretary reported for the Executive Committee as follows:

"That at a recent meeting the Executive Committee had:

- "1. Moved that any member of the Providence Medical Association eligible for transfer to the newly formed Bristol County Medical Association shall also be eligible for associate membership in the Providence Medical Association upon application; and further, any Bristol County Association member who has paid the 1947 assessment

## RHODE ISLAND MEDICAL JOURNAL

to the Providence Medical Association shall be refunded the payment.

- "2. Moved that the President be authorized to appoint a committee to revive and publicize the prize case report contest along the lines of the contest initiated in 1941.
- "3. Authorized the Centennial Committee to engage such clerical assistance as may be needed, and to expend funds at the discretion of the President, the Treasurer, and the Chairman of the Centennial Committee for the proper observance of the Association's centennial in January, 1948.
- "4. Referred to the Council of the State Medical Society a study on fees paid by insurance companies for medical examinations and reports."

By a motion from the floor the report of the Executive Committee was accepted and placed on file.

Dr. Wells made the following announcements:

"That on Friday, May 16, at 8:15 p. m., the St. Joseph's Hospital Staff Association will hold its monthly meeting in the Nurses' Auditorium on Peace Street. The speaker will be Dr. James F. Norton, M.D., F.A.C.S., Clinical Professor of Obstetrics, Faculty of Medicine, Columbia University; and Chief of Obstetrics, Margaret Hague Maternity Hospital, Jersey City, and also chief of Obstetrics at St. Mary's and St. Francis Hospitals in Hoboken, New Jersey. Dr. Norton is also Vice-President of the New Jersey State Medical Society.

He stated that all physicians are invited to attend this meeting as guests of the St. Joseph's staff.

Dr. Wells also called to the attention of the members of the Association the fact that the 136th Annual Meeting of the Rhode Island Medical Society would be held at the Medical Library on May 14 and 15.

Dr. Wells reported that the obituary tribute to the late Dr. Salvatore Castallo had been prepared by Dr. Vincent J. Oddo and Dr. Angelo Scorpio, and that it had been filed with the Association for permanent record.

The Secretary reported that the Executive Committee recommended for active membership in the Association the following physicians: Enzo J. Fruggiero, M.D., Herbert F. Hager, M.D., Joseph A. Palumbo, M.D., Richard K. Whipple, M.D.

Dr. William M. Muncy moved that the applicants recommended be elected to active membership. The motion was seconded and unanimously adopted.

Dr. Wells introduced as the first speaker on the scientific program Raymond M. Young, Ph.D., bacteriologist at the Rhode Island Hospital, whose

*continued on page 481*

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## PROVIDENCE MEDICAL ASSOCIATION

*continued from page 478*

topic was "The Newer Knowledge of Viruses."

Virus are divided into two groups, one like bacteria only much smaller and the other non-living enzyme agent. With better microscopes they can now be seen equally. Small-pox virus can be seen multiplying by fission; they are about 10-30 millimicrons in size, a size that approaches that of the larger molecules.

Virus may be produced in tissues when proper stimulation is applied. The stimulation may be chemical or a toxin of abnormal metabolism.

## Epidemiology of Virus Infection.

Mumps, chickenpox, and encephalitis are disseminated by droplet infection. Poliomyelitis is now said to be transmitted through the alimentary tract, thence to sympathetics to medulla. The presence of polio virus in sewage is a potential source of infection.

Infectious hepatitis is also transmitted through the stools. Insects also transmit some virus agents. Between epidemics virus live in intermediate hosts. Hemoagglutination tests taken at onset of disease and during convalescent phase and compared show increase in antibodies during the convalescent phase. The complement fixation test is well adapted to the diagnosis of virus infection. Skin tests are not very good in diagnosis of virus infections, the Frie test in lymphogranuloma venereum is an example.

## Prophylaxis and Therapy.

These agents are refractory to antibiotic drugs; Psittacosis and lymphogranuloma venereum are said to respond to sulfa drugs. In many cases attenuated virus gives protection e.g., Rabies. The more viable the virus the greater the degree of protection. Treated yellow fever virus is now safe for human immunization. Pooled serum is useful in measles, mumps and polio.

The second speaker was Dr. Russell S. Bray, physician and Director of the Gastro-Intestinal Department, Rhode Island Hospital, who spoke on "Clinical Aspects of Certain Functional Disorders of the Biliary Tract."

The basic physiological change seems to be an impediment to the flow of bile from the liver to the duodenum. Functional disturbance can cause obstruction, usually at the Sphincter of Oddi due to simple spasm.

Gall Bladder colic can occur without stone or disease and is due to hypertonic contraction of the gall bladder against a spastic sphincter.

Stasis of the gall bladder with distension can cause symptoms of cholecystitis and bring about a favorable environment for development of calculi and changes in the mucosa. Other hollow viscera which are innervated by the same nerves can produce symptoms which may confuse one.

Many cholecystectomized patients show mid-epigastric pain, left costal border pain, flatulence epigastric fullness, etc. Nerves, marital difficulty, nervous tension bring on attacks. Cholecystography and non-surgical bile drainage is used to study these patients.

In non-cholecystectomized patients all showed delayed evacuation after a fatty meal. Minor pathological changes exist even when the dye is well concentrated. Bile from cholecystectomized patients showed concentration. A constant finding in all cases was precipitated cholesterol crystals during an attack, none during an asymptomatic period. Because of this, biliary cholesterosis is a better term than biliary stasis. Therapy in these cases consists in avoiding overeating, giving small frequent feedings and giving dehydrocholic acid to help bile flow. Also, there is great benefit from gall bladder drainage. Anti-spasmodics also help. There is no constant relationship between the severity of the symptoms and the pathology in the gall tract.

Attendance: 71.

Collation was served.

The meeting adjourned at 9:55 p. m.

Respectfully submitted,

DANIEL V. TROPOLI, M.D.

*Secretary*

## PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at 9:00 p. m. April 17, 1947, in the Nurses' Auditorium of the Memorial Hospital. Twenty members attended.

The meeting was called to order by the President, Dr. Earl J. Mara. The minutes of the previous meeting were read by the Secretary and approved.

The applications for membership in the Association of the following physicians were read and referred to the Standing Committee: Drs. Shavarsh Markarian, Nathan Sonkin, and Robert Jerome DuWors.

Dr. Mara reported that over 50 per cent of the members of the Association had enrolled in the Loyalty Group Professional Disability Plan. An extended period of 18 days was granted, during which time those members of the Association who desired could enroll without submitting to physical examination.

Dr. Mara introduced the speaker of the evening, Dr. Francesco Ronchese, Dermatologist-in-Chief of the Rhode Island Hospital, who spoke at length on "Occupational Marks," illustrating his remarks with a series of excellent lantern slides.

The meeting adjourned at 10:30 p. m. A collation was served.

Respectively submitted,

KIERAN W. HENNESSEY, M.D.,

*Secretary*

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\*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.



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## EMIC PROGRAM INFORMATION

TO: State Health Officers  
FROM: Edwin F. Daily, M.D., Director, Division of Health Services  
SUBJECT: Action by the Congress on the Emergency Maternity and Infant Care Program

On May 7, 1947, I directed a memorandum to you on the expected action by the Congress on the EMIC program and pointed out the action taken by the House of Representatives. Now the Senate has taken similar action on the EMIC program. Therefore, for the fiscal years 1948 and 1949, Fund E may continue to be used for—

1. The completion of all maternity and infant care for wives or infants for whom initial care was authorized prior to June 30, 1947, at the rates established in the official State plan.
2. Maternity care authorized after June 30, 1947, if the mother was eligible under the program

as of June 30, 1947, even though she may apply for care subsequent to that date.

3. Infant care authorized after June 30, 1947, if the mother or infant was eligible for care or received care under the program as of June 30, 1947. For example, if the wife of an enlisted man in the eligible pay grades became pregnant before June 30, 1947, she would be eligible to apply for and receive services under the EMIC program until 6 weeks postpartum, and her infant would be eligible for service provided under the program until 1 year of age.

4. Costs of administering the EMIC program. Information concerning these changes in the program should be made known through all possible channels of publicity to reach as many of the families of enlisted men as possible, to all physicians, hospitals, and others participating or interested in the program.

Requests for Fund E, reports of expenditures, etc., should be continued as in the past until all cases are completed.

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**Herman von Helmholtz**

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Although the inventor of the ophthalmoscope, Helmholtz's greatest contribution to medicine was his exhaustive researches on the mechanism of accommodation and the problem of color vision. The famous Young-Helmholtz theory of color vision resulted from his studies which confirmed and elaborated the findings of Young. His every work showed—*experience is the best teacher!*

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**D**URING the wartime cigarette shortage, people smoked many different brands—more than they would normally try in years. That's how so many learned the differences in cigarette quality. And from that experience millions more smokers came to prefer Camels. Today more people are smoking Camels than ever before.

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## BOOK REVIEWS

*REHABILITATION THROUGH BETTER NUTRITION.*

By Tom. D. Spies, M.D., Philadelphia: W. B. Saunders Company.

Many of the results of Dr. Spies' study of nutritional deficiencies in the Nutrition Clinic of Hillman Hospital in Birmingham, Ala., and the conclusions based on these results are contained in this 94 page monograph. The report covers more than a ten year period of time, during which over 10,000 patients were examined. For the most part, only essential data is given and many of the pages are covered by one or more of the 50 figures. Some of these figures are color or plain photographs illustrating deficiency diseases, while others are tabular or graphic presentations of the compiled statistics. The excellent descriptions of the more common nutritional deficiency diseases with illustrations and the statement of the principles of treating these deficiencies will attract the practicing physician. The monograph will not serve as a handbook of dietary therapy. Statistics dealing with the incidence of nutritional disease and dietary inadequacies will primarily interest workers in the field of Public Health, however, only the minimal statistical information is included. There is disparity between the title and the bulk of the subject matter of this monograph. The title is misleading if one should look to the monograph for help and aid in the long range management of nutritional diseases or expect to find a detailed report of the rehabilitation achieved at the Hillman Hospital. Short range treatment of deficiency diseases is better covered than the long range, and then primarily discussed in principle. Specific treatment for specific deficiencies is illustrated by case histories. Despite the shortcomings of the monograph, namely the misleading title and lack of balance in the presentation of material, the book will be profitably read by the medical profession because the therapeutic principles and clinical opinions of Dr. Spies are sound, forthright, and above all, authoritative.

ROBERT V. LEWIS, M.D.

*GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY.* By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin) F.A.C.S. Second Edition with 542 Illustrations, 15 in Color, 545 pages. W. B. Saunders Company, Philadelphia and London, 1947. \$7.50.

This recent edition of Dr. Novak's excellent book is a thorough revision and brings the knowledge of obstetrical and gynecological pathology up-to-date. The addition of over one hundred illustrations, fifteen in color, further increases its value. The reference lists now include major contributions through 1946.

It is not, and it is not intended to be, an encyclopedic volume. Its concise and logical form, succinct presentation and complex index make it a ready reference manual to the more frequently encountered pathological conditions. The first edition has gained the stature of a standard text, and this recent revision is a welcome continuation of an authoritative and scientific work.

WILLIAM A. REID, M.D.

#### HEALTH AND ACCIDENT INSURANCE

Members of the Society are urged to check carefully on offers sent through the mail offering invitations to participate in an offer of a strictly non-cancellable policy providing lifetime benefits. Several inquiries have come to the executive office from members in the past month regarding such offers.

Two of the companies making the offer are *NOT* licensed in Rhode Island. Hence they resort to appeals by mail. The purchaser of such a policy runs the risk of having to travel to the home office of the company, or even engaging legal counsel to press a claim for benefits. And none of the contracts are as strictly non-cancellable as they are represented to be.

Check the state insurance commissioner's office before buying any such contracts. Or call your executive office for information.



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